

## 03922

VR A15 (4)  
20 M 1/68

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23  
Cleared with coroner  
MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03325

CERTIFICATE OF DEATH

03923

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in lb <b>7 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		d. STREET ADDRESS <b>2206 Pimmit Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Lynne</b> Last <b>Rice</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 February 1944</b>
9. AGE (In years last birthday) <b>23</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jay C. Rayner</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Woods</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas Septicemia</b> DUE TO (b) <b>Perirectal Abscess</b> DUE TO (c) <b>Acute Lymphocytic Leukemia</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>March 3</b> , 19 <b>67</b> , to <b>March 10</b> , 19 <b>67</b> that <del>he</del> (we) last saw the deceased alive on <b>March 10</b> , 19 <b>67</b> , and that death occurred at <b>3:40 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Jerry L. Spivak</b>		22b. DATE SIGNED <b>11 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry L. Spivak, MD.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 14, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sparta Presbyterian</b>	23d. LOCATION (City or Town) (County) (State) <b>Sparta, New Jersey</b>
24. FUNERAL DIRECTOR <b>Clark E. Warner</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S ADDRESS <b>4434 Georgia Avenue Silver Spring, Md.</b>	

03253

174-11-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03926

CERTIFICATE OF DEATH

03924

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda,</u> <u>15.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4977 Battery Lane Apt. 42</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Ruth Jones Richards</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>16-16-05</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Josiah Watters Jones</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Sherman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>151-34-7374</u>		17. INFORMANT Address: <u>Rockville, Maryland</u> <u>James A. Richards -son- 1620 Burriss Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Deep vein thrombosis</u> DUE TO <u>Myelogenous Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myelogenous Leukemia</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-23-</u> , 19 <u>65</u> , to <u>3-20-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-19</u> , 19 <u>67</u> , and that death occurred at <u>          </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W. T. Joyce</u>				22b. DATE SIGNED <u>3-20-67</u>		22c. PHYSICIAN'S NAME (Type) <u>W. T. Joyce</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>3/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				23d. LOCATION (City or Town) (County) (State) <u>Prince George co. Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>							

ASBGO

STATE OF NEW YORK

ASBGO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03927 CERTIFICATE OF DEATH 03025

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutional residence, please admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. LENGTH OF STAY IN ID <b>5 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda - Silver Springs N. H.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 47-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>935 15TH ST. SE.</b>			
3. NAME OF DECEASED (Type or print) First <b>ERNESTINE</b> Middle <b>ROBERTSON</b> Last				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-13-1891</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ERNEST SEBOLD</b>				14. MOTHER'S MAIDEN NAME <b>EDNA JOHNSON HENNECKE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>VIRGINIA HAUSSLER</b>		Address <b>46 OLD MILL RD MANHASSET, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> <b>1538</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Suspected colonic malignancy</b> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myeloid metaplasia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1965, to <b>March 24</b> , 1967, that (I) (we) last saw the deceased alive on <b>March 17</b> , 1967, and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard Kaufman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD KAUFMAN</b>				22d. ADDRESS <b>916 19th St. NW Wash. DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-28-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR <b>LEE FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>300 4TH ST. N.E. WASH. DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
 HEALTH DEPT

03928

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03926

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> d. STREET ADDRESS <b>8207 ROANOKE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MR. ABRAHAM NONE ROBINSON</b>		4. DATE OF DEATH Month Day Year <b>MARCH 22 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>? 1887</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GARDNER-RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>	
13. FATHER'S NAME <b>TOM ROBINSON</b>		14. MOTHER'S MAIDEN NAME <b>ISABELLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Keap</b> EXAMINER'S NAME (Type) <b>BELDEN R. KEAP, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town or County) <b>Rockville, Md.</b>	
22. DATE SIGNED <b>3/22/1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Sandy Spring Montg Md.</b>
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		25a. REC'D BY REGISTRAR <b>MAR 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

1938

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A (4)  
20 M 1/66

03929

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03927

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FEKLA Petrovna ROMANENKO</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED XX</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1900</b>
9. AGE (In years lost birthday) <b>66 yrs</b>		10. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter KIRIENKO</b>		14. MOTHER'S MAIDEN NAME <b>Vassa GOOSLOVA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>116 28 1201</b>	
17. INFORMANT <b>7424 Bethune St., Falls Church, Va.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Cerebral Metastatic Disease</b> DUE TO <b>Secondary to Cancer of Breast</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>Feb. 15, 1967</b> , to <b>March 4, 1967</b> , that (X) (we) last saw the deceased alive on <b>March 4, 1967</b> , and that death occurred at <b>5:50 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>R. J. Cavanagh</b>		22b. DATE SIGNED <b>4 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. J. CAVANAGH, LT MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Type)	23b. DATE THEREOF <b>3/9/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Falls Church Funeral Home</b>		25. REC'D BY REGISTRAR <b>MAR 8 1967</b>	
26. ADDRESS <b>1102 W. Broad St., Falls Church, Va.</b>		27. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1951

1952

1953

1954

03930

CERTIFICATE OF DEATH

03928

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>11804 Lovejoy ST</u>	
3. NAME OF DECEASED (Type or print) <u>Gwendolin Roberta Rotondaro</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Turner Clinedinst</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Stedman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Carmine Rotondaro</u>		Address <u>11804 Lovejoy Street Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450X ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>WEGENER'S GRANULOMATOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>4 YEARS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 DAYS POST-OP CRANIOTOMY (WEGENER'S GRANULOMATOSIS)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> , 19 <u>67</u> , to <u>MARCH 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 20</u> 19 <u>67</u> , and that death occurred at <u>10 A.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward A. Beeman</u>		22b. DATE SIGNED <u>MARCH 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>		22d. ADDRESS <u>1015 SPRING ST. SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>Glen Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 27 1967</u>	

MEDICAL CERTIFICATION  
Cleared with Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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4

1

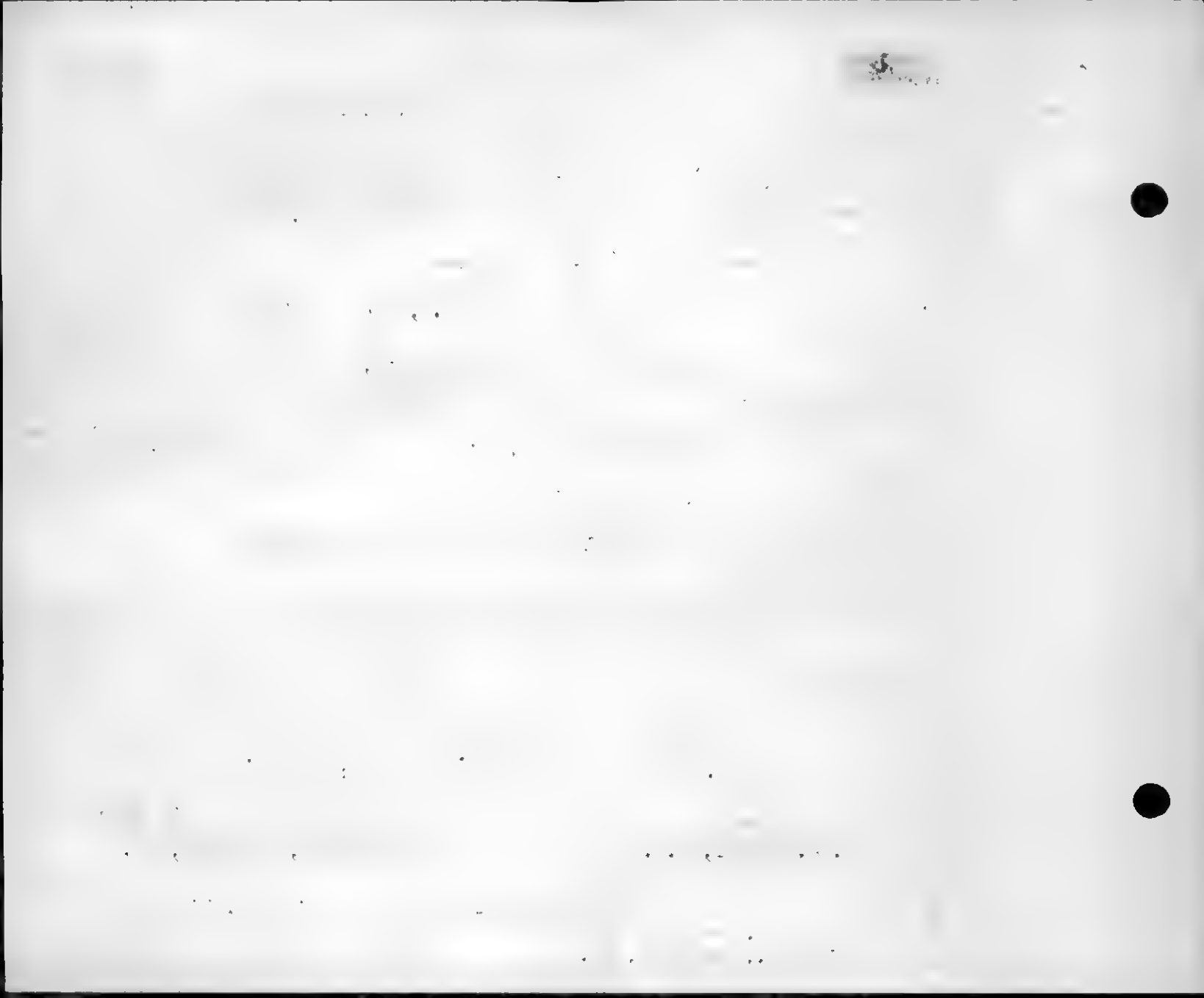
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23b Film #G387 1737 pc

03931

CERTIFICATE OF DEATH

03929

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN TB <b>24 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>North Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Arlington</b> d. STREET ADDRESS <b>4864 33rd Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joan</b> Middle <b>(NMN)</b> Last <b>Rowe</b>		4 DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 5, 1894</b>
9. AGE (in years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Edinburgh, Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Usa</b>	
13. FATHER'S NAME <b>Alexander Dalrymple</b>		14. MOTHER'S MAIDEN NAME <b>Janet Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>149 05 7739B</b>	
17. INFORMANT <b>Julia Rowe</b>		Address <b>North Arlington 4864 33rd Road Virginia</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 19</b> , 19 <b>67</b> , to <b>Mar. 15</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Mar. 15</b> , 19 <b>67</b> , and that death occurred at <b>11:00 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>R. J. Kinney</b>		22b. DATE SIGNED <b>17 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. J. KINNEY, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
<b>7557 Wisconsin Ave., Bethesda, Md.</b>		DATE <b>MAR 28 1967</b>	



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VR A15 (4)  
20 M 1/66

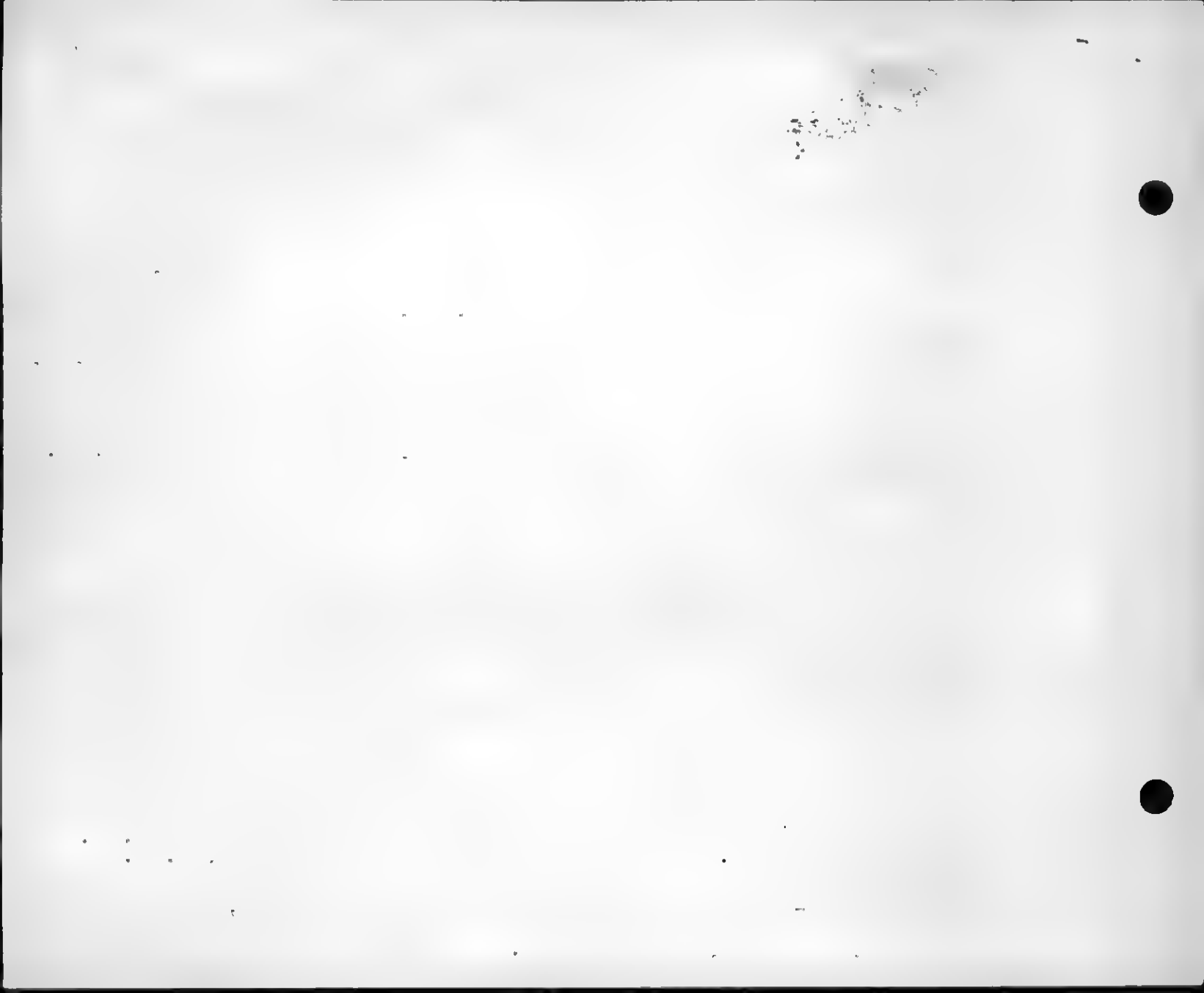
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03932

03930

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Travilah</b>		c. LENGTH OF STAY IN 1b <b>17 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Query Mill Road</b>		d. STREET ADDRESS <b>Query Mill Road</b>	
3. NAME OF DECEASED (Type or print) <b>REMO</b>		4. DATE OF DEATH <b>March 1, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hairdresser</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Antonia Rubino</b>		14. MOTHER'S MAIDEN NAME <b>Ermiria Cernelli</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wife Evelyn V. Rubino</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension Arteriosclerotic Heart Dis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>5 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-24, 1961</b> to <b>3-1, 1967</b> , that (I) (we) last saw the deceased alive on <b>2-22, 1967</b> , and that death occurred at <b>4<sup>th</sup> A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Alvin I. Kay</b>		22b. DATE SIGNED <b>3-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALVIN I. KAY</b>		22d. ADDRESS <b>1835 I Street, N. W. Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Potomac, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>		25. REG. D. BY REGISTRAR <b>MAR 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

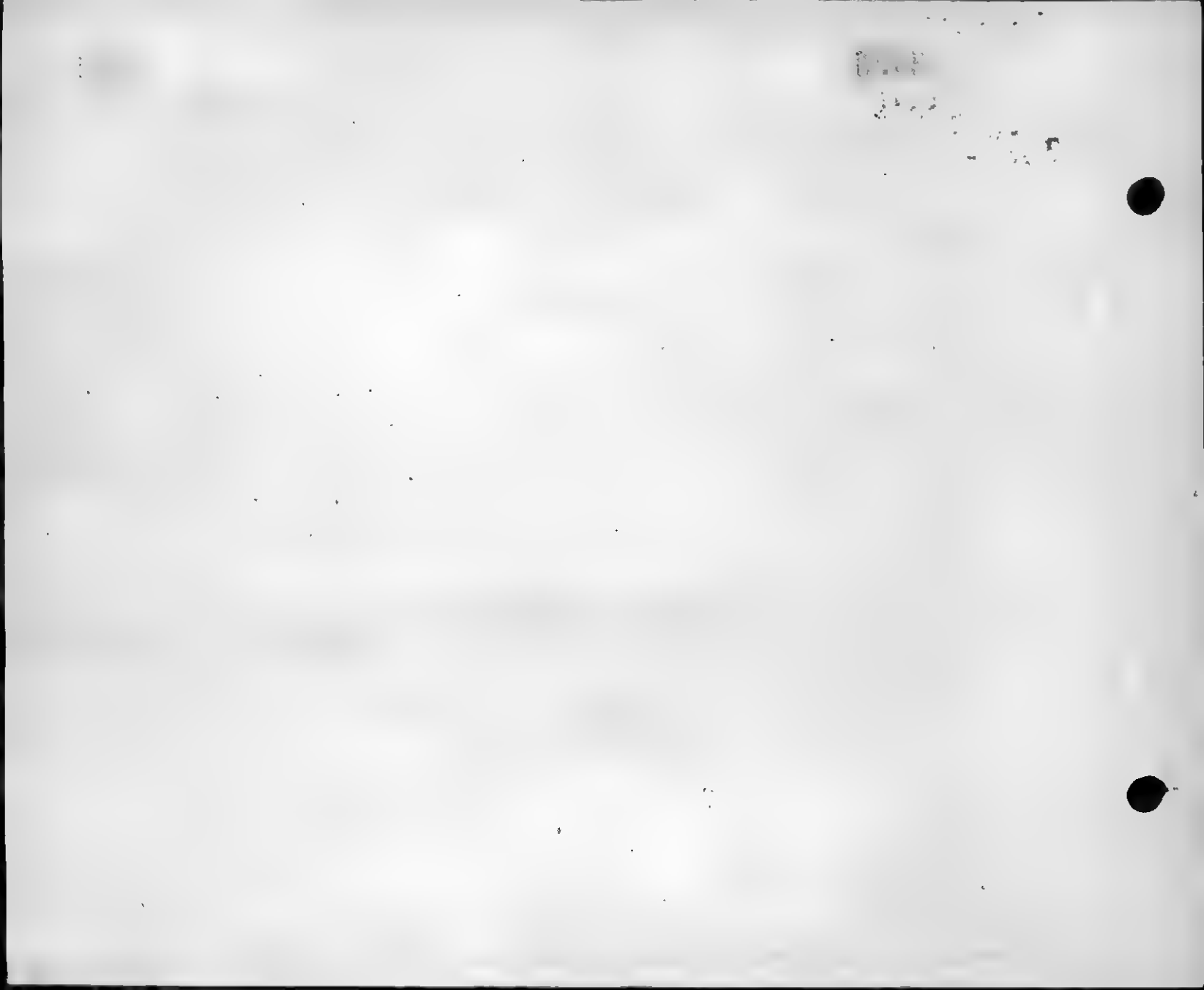


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**03933** **CERTIFICATE OF DEATH** **03931**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON DC 20016</b> c. LENGTH OF STAY IN 1b <b>10 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6102 MASS. AVE.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington DC 20016</b> d. STREET ADDRESS <b>6102 MASS. AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>BESSIE</b> First Middle Last 4. DATE OF DEATH <b>March 30</b> 1967 Month Day Year			5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>APR 16, 1881</b> 9. AGE (In years last birthday) <b>85</b> yrs. 10. UNDER 1 YEAR Months Days Hours Min. 11. UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>home</b> 11. BIRTHPLACE (County & State, or foreign country) <b>BESSARABIA, ROMANIA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>SHEPSI MENDEL BALAN</b> 14. MOTHER'S MAIDEN NAME <b>CHANA RUCHEL WAX</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>577-24-1313</b> 17. INFORMANT <b>MRS. IDA SHERMAN</b> Address <b>6102 MASS. DC 20016</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary heart disease</b> DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>10 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 7, 1964</b> to <b>Mar 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>Mar 30, 1967</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>M. van Kinsbergen</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>3-30-67</b>			22c. PHYSICIAN'S NAME (Type) <b>DR. M. VAN KINSBERGEN</b> 22d. ADDRESS <b>5715 MASS. AV. WASH DC 20016</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>4/2/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>D.C. LODGE CEM.</b> 23d. LOCATION (City, town or county) (State) <b>WASH. D.C.</b>			24. FUNERAL DIRECTOR <b>GOLDBERG FUNERAL HOME</b> ADDRESS <b>4217-9</b> 25a. REC'D BY REGISTRAR <b>APR 4 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





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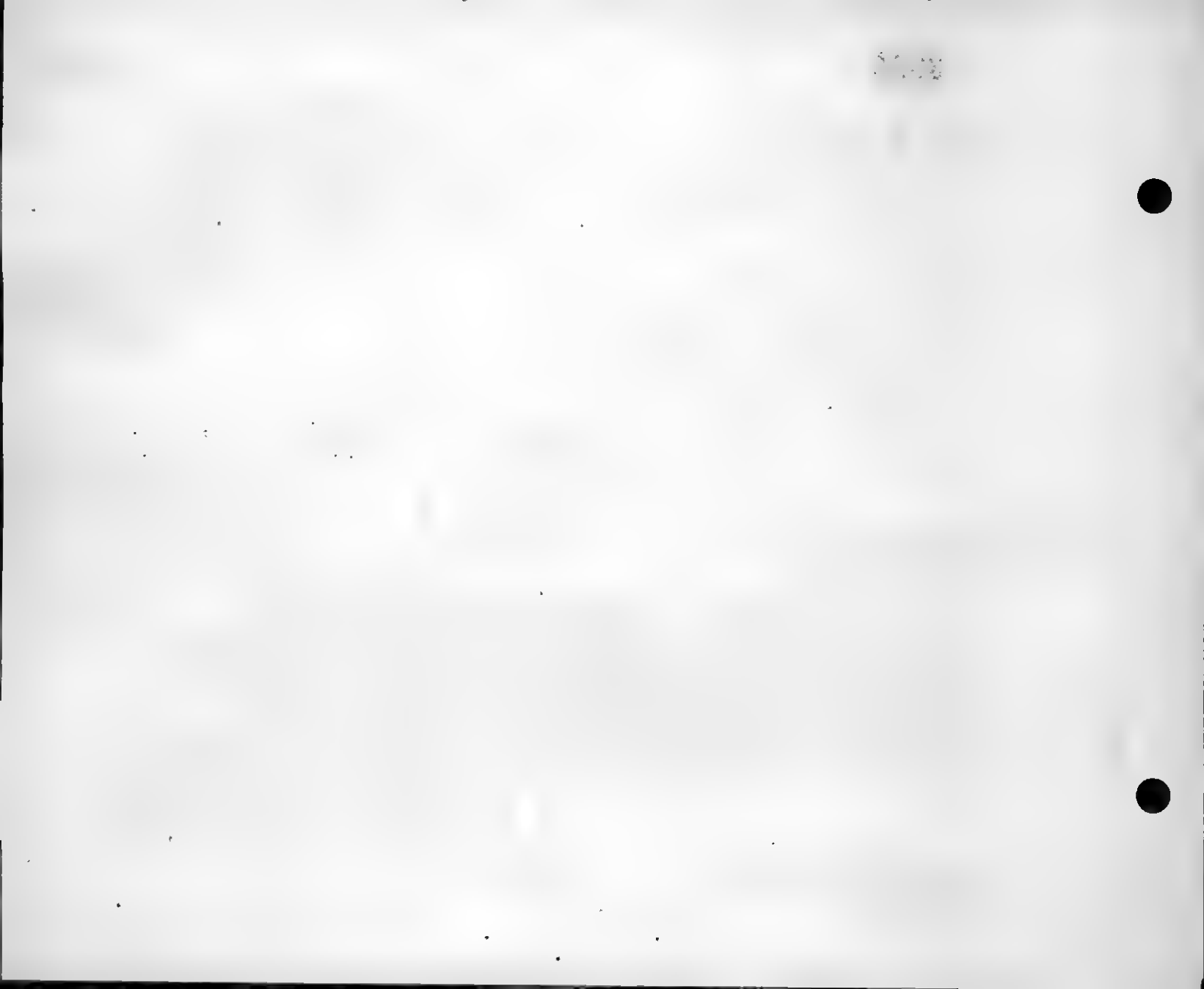
MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03934

CERTIFICATE OF DEATH

03932

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY -----	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>74 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>		d. STREET ADDRESS <b>4918 Celtic Drive, Apt. 101</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edith Elizabeth Rush</b>		4. DATE OF DEATH Month Day Year <b>March 17 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 May 1897</b>
9. AGE (In years last birthday) <b>69 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry W. Honan</b>		14. MOTHER'S MAIDEN NAME <b>Louise Plumley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Not Available</b>	
17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO (b) <b>Intestinal Obstruction</b> DUE TO (c) <b>Metastatic malignant carcinoid</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 minutes</b> <b>3 weeks</b> <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>2 January, 19 67</b> , to <b>17 March, 19 67</b> , that (X) (we) last saw the deceased alive on <b>17 March 19 67</b> , and that death occurred at <b>4:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John P. Kokko</b>		22b. DATE SIGNED <b>17 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>John P. Kokko</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		23d. LOCATION (City or Town) (County) (State) <b>Chester, Pa.</b>	
24. FUNERAL DIRECTOR <b>John P. Kokko</b>		25. MAR 21 1967	
25a. ADDRESS <b>1500 W. Braddock Rd. Alexandria, Va.</b>		25b. REGISTRAR'S SIGNATURE <b>John P. Kokko</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03935

03933

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Tuberculosis</u>				d. STREET ADDRESS <u>11-N. Cherry Grove Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Calvin Russell</u>				4. DATE OF DEATH Month Day Year <u>March 22 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/46</u>	9. AGE (In years last birthday) <u>20</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Mason Russell</u>				14. MOTHER'S MAIDEN NAME <u>Jackie Trumpower</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT Address <u>CHARLES M. RUSSELL #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Injuries multiple and severe</u> <u>8234</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto accident</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Lost control of car left highway &amp; struck a light pole</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> <u>p.m.</u> <u>3/22 1967</u>		20d. INJURY OCCURRED Where <input type="checkbox"/> Nat <input type="checkbox"/> While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Bethesda Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u>		EXAMINER'S NAME (Type) <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>3/23/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR 25 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR-SON ANNAPOLIS MD.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1954

3-

1954-1955

1954-1955

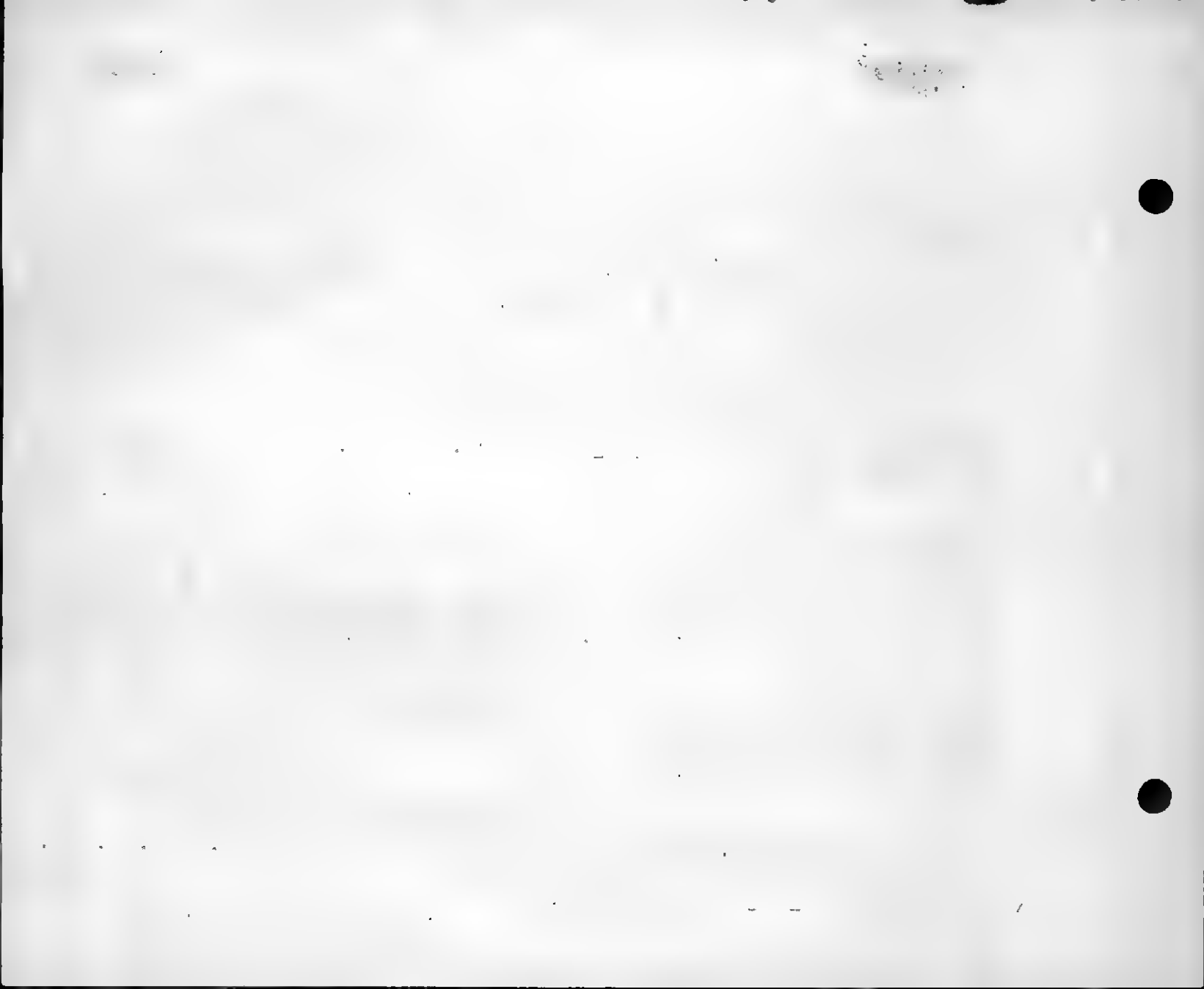
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 - Cleared & Dr. Medical Examiner 3/19/67

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
03936					CERTIFICATE OF DEATH					03934				
1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN IS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			d. STREET ADDRESS <u>609 Mc NEILL</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>														
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>M</u> Last <u>RYAN</u>					4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-83</u>		9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Post Office Dept</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>George Thompson</u>					14. MOTHER'S MAIDEN NAME <u>Mary Richardson</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>215-44-4169T</u>		17. INFORMANT Address <u>Mrs. Bertha R. May (same as #2)</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Colon &amp; Metastases</u> <u>1038</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>8-10 mo</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Chronic Decompensation</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>1955 to 19 March 1967</u> that (I) (we) last saw the deceased alive on <u>11 March 1967</u> , and that death occurred at <u>10:40 P.M.</u> from causes and on the date stated above.														
22a. SIGNATURE <u>William D. Aud</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>William D. Aud</u>					22d. ADDRESS <u>9006 Galesville Rd. Sil. Sp. Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>			23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>Bladensburg Maryland</u>						
24. FUNERAL DIRECTOR <u>W. J. Hopkins</u>					ADDRESS <u>23414 11th Ave. N.W.</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					





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Cleared & Medical Examiner 3/28/67

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

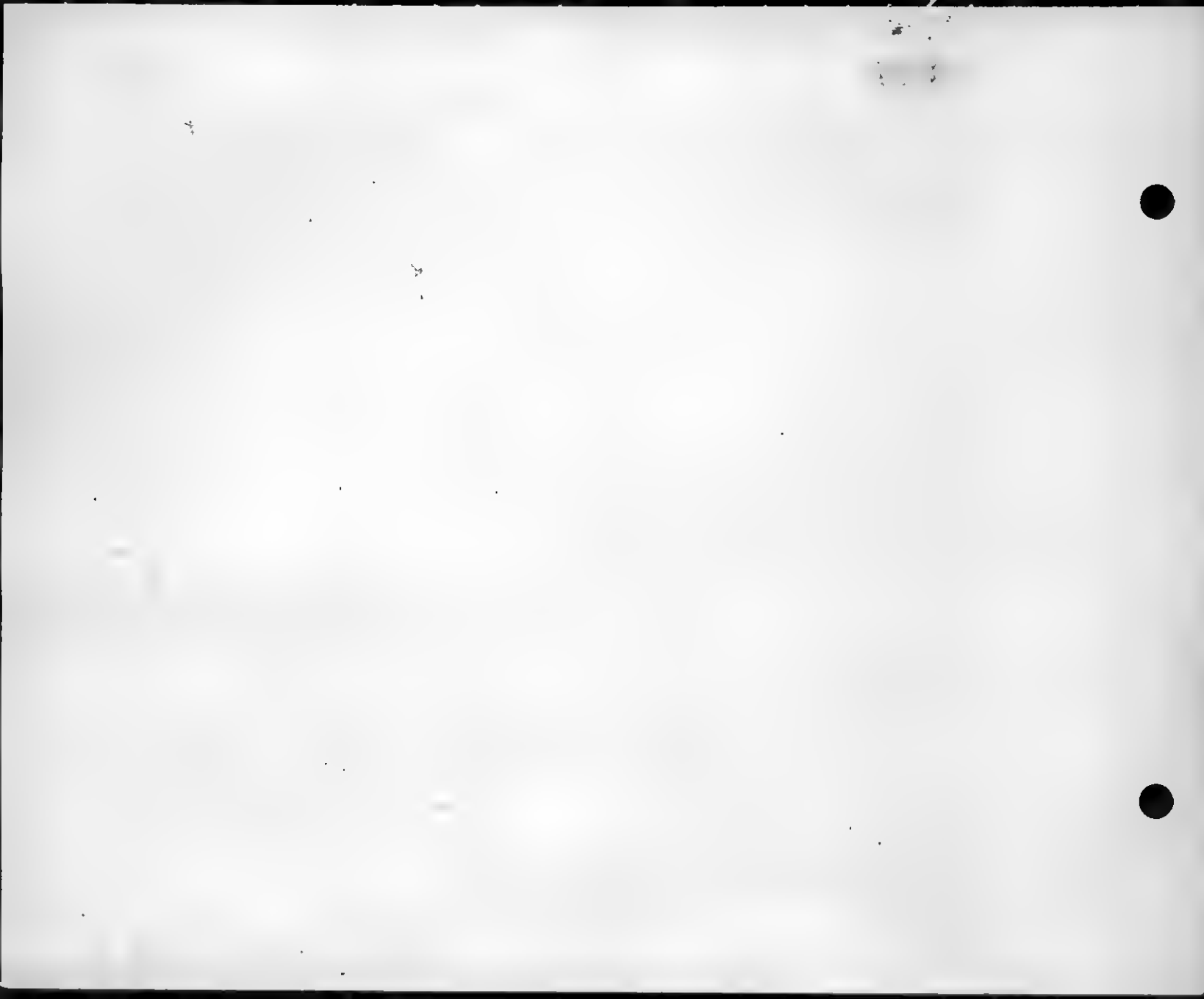
03937

Item #8 Film #03937 4/3/67 pc

CERTIFICATE OF DEATH

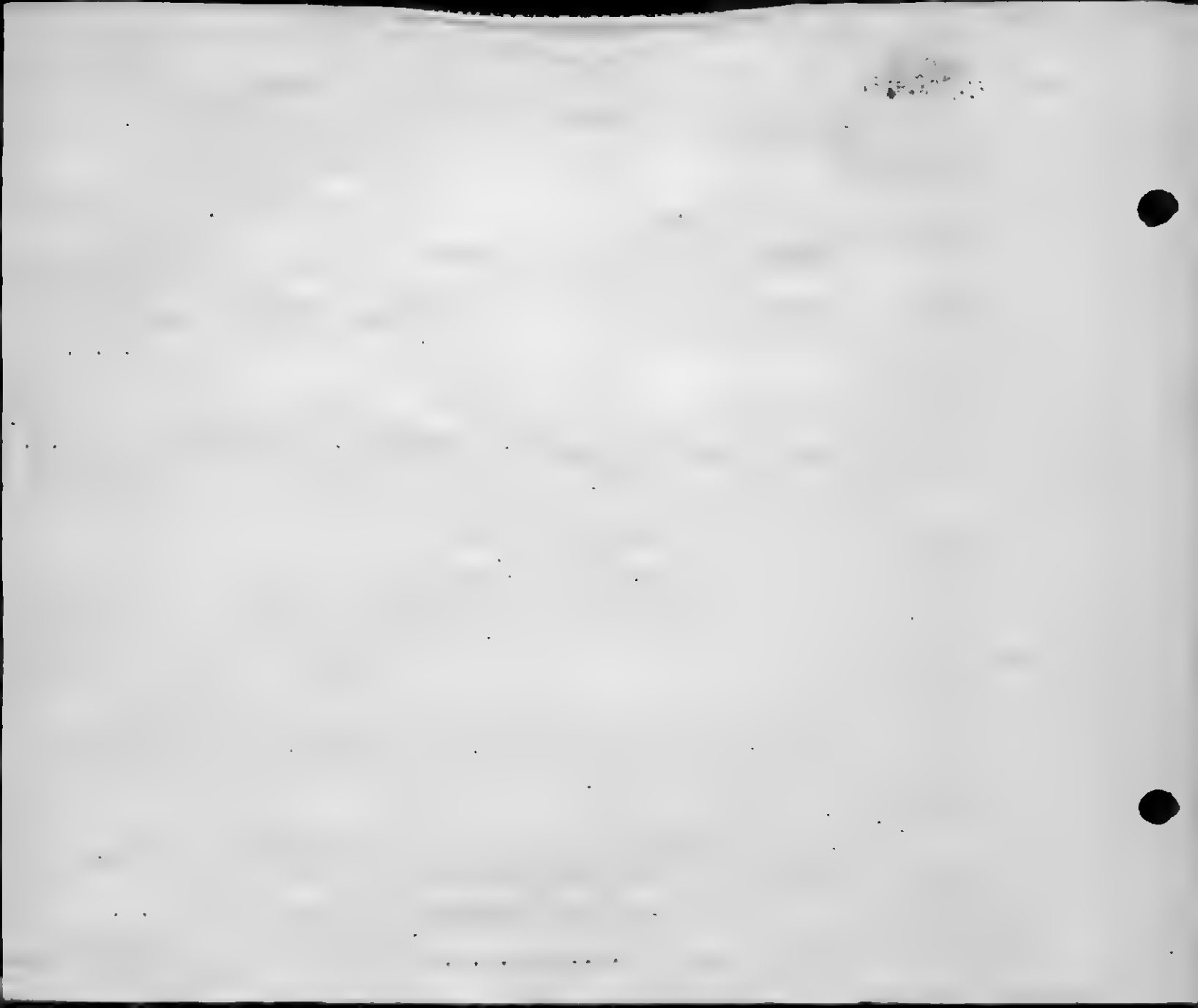
03935

1 PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. LENGTH OF STAY IN 1b <u>3/26/67-3/28/67</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyatts md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>				d. STREET ADDRESS <u>8002-14th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Sophie</u> Middle <u>Sacks</u> Last <u>Sacks</u>				4 DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/1904</u> <u>7/1/1957</u>	9 AGE (In years lost birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>TURNER</u>				14 MOTHER'S MAIDEN NAME <u>TOBY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>HUSBAND</u> Address <u>12100RE SACKS - ITEM 2. ABOVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Diabetic acidosis</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>36 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 20</u> , 19 <u>66</u> , to <u>March 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 28</u> , 19 <u>67</u> , and that death occurred at <u>1:45 AM</u> , from causes and on the date stated above.							
22a SIGNATURE <u>Raymond Bradshaw</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw MD</u>				22d. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH ISRAEL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WOODBRIIDGE N.J</u>	
24 FUNERAL DIRECTOR <u>BERNARD DANZANSKY SONS - WASH. D.C.</u>				25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03938					03936				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>					b. COUNTY <b>Montgomery</b>				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Randolph Hills Nursing Home</b>					d. STREET ADDRESS <b>629 Northwood Terr.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>SARAH</b>					4. DATE OF DEATH <b>3 31 19 67</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>10/10/86</b>				
9. AGE (In years last birthday) <b>80 yrs.</b>					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Samuel Eli Tash</b>					14. MOTHER'S MAIDEN NAME <b>Rebecca Katz</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Mrs. Lewis Goss, 629 Northwood Terr.</b>					Address <b>Md. S.S.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of Right Leg</b> DUE TO <b>Arteriosclerosis</b> (b) <b>Essential Hypertension</b> DUE TO <b>Arteriosclerosis</b> (c) <b>Essential Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage with Hemiplegia -</b>									
INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>20 years</b> <b>25 years</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (the hospital) attended the deceased from <b>Jan. 25, 1967 to March 31, 1967</b> that (I) (we) last saw the deceased alive on <b>3/31, 1967</b> and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Samuel Dean</b> M.D.									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL DEAN</b>									
22d. ADDRESS <b>1302 - 18th N.W. WASH. D.C.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
23b. DATE THEREOF <b>4/2/67</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Elesavetgrad Cemetery</b>									
23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons</b>									
ADDRESS <b>3501-14th St. N.W., Wash. D.C.</b>									
25. REC'D BY REGISTRAR <b>APR 4 1967</b>									
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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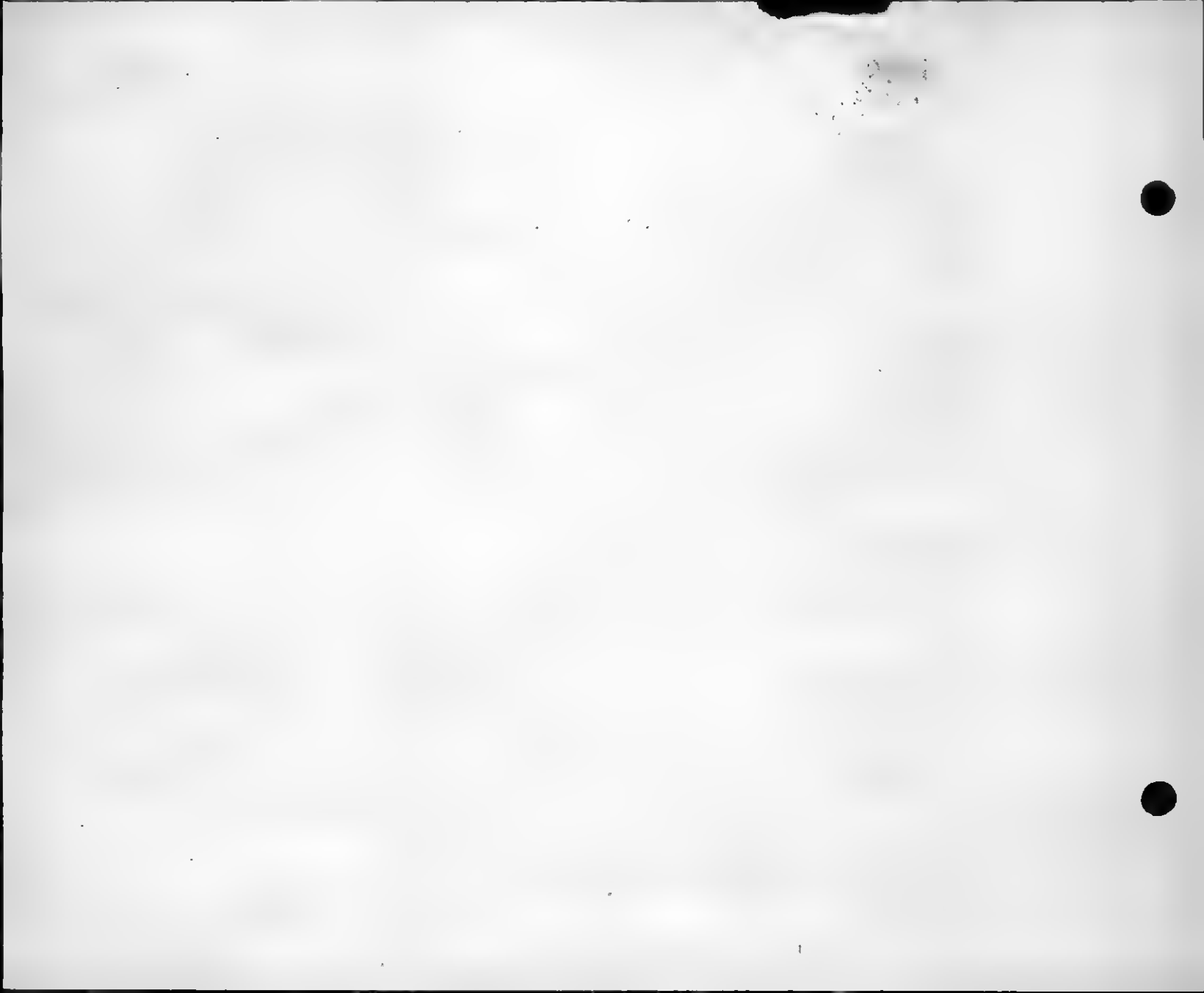
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03939

## CERTIFICATE OF DEATH

03937

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda-Silver Spring Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>4000 Massachusetts Ave., NW</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CARL</b> First <b>Bradley</b> Middle <b>SALTS</b> Last		4. DATE OF DEATH Month <b>3</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-5-1904</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pepsi-Cola Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Tenn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Albert Salts</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Payne</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO		17. INFORMANT <b>Gladys M. Salts, Wife, Same as #2 above</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Art Disease</b> DUE TO (c) <b>Severe Generalized Arteriosclerosis.</b> INTERVAL BETWEEN ONSET AND DEATH <b>min</b> <b>1458</b> <b>1955</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>OCT 1959</b> to <b>10-20-1967</b> , that (1) (we) last saw the deceased alive on <b>3/20-1967</b> and that death occurred at <b>2:30</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>James R. Nugent</b> M.D.		22b. ADDRESS <b>4000 Mass Ave N.W. Wash D.C.</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES R. Nugent</b>		22d. DATE SIGNED <b>3/20/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>3/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., Washington, DC</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

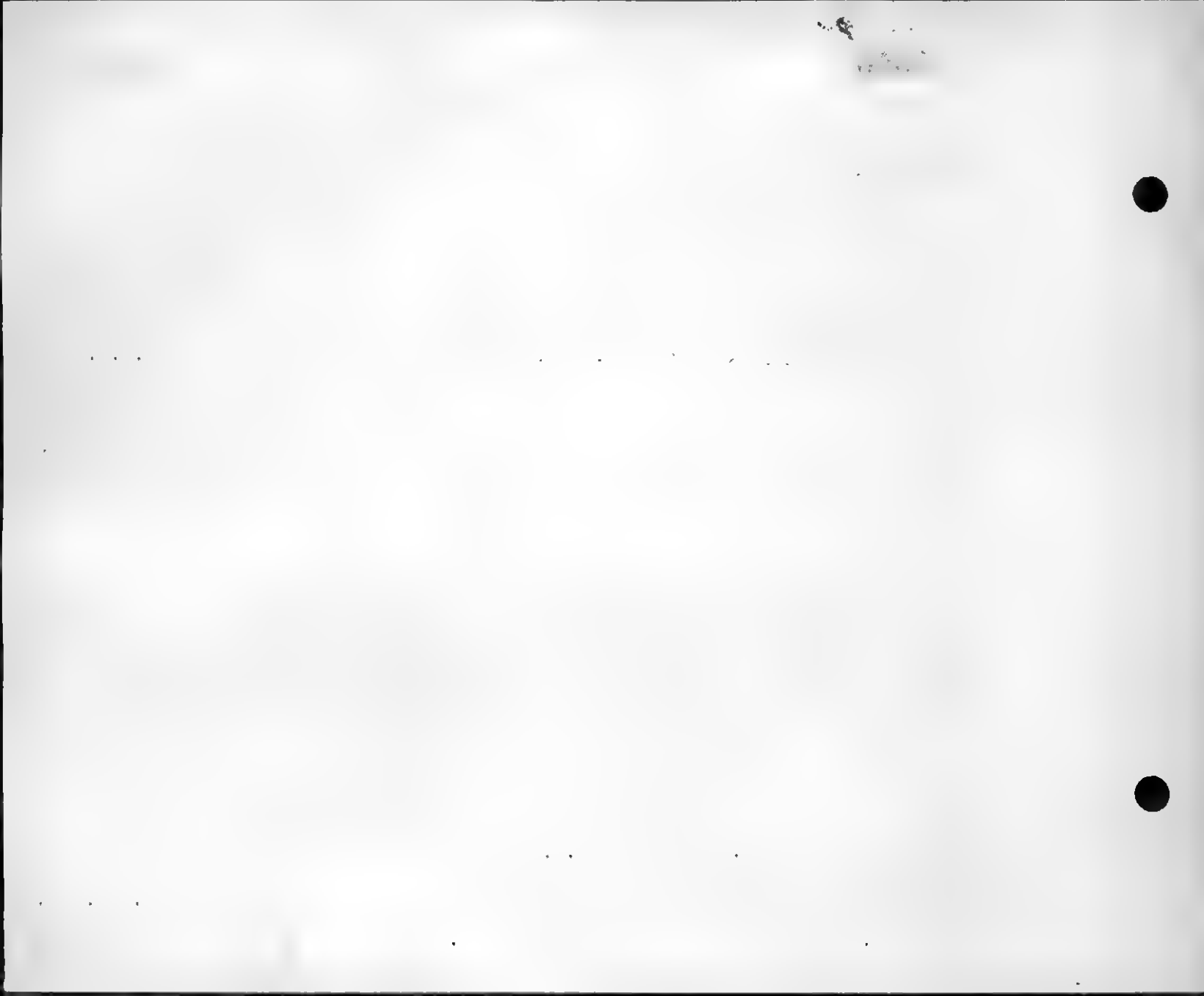
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03940

03938

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN b <b>Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7620 Maple Avenue</b>		d. STREET ADDRESS <b>7620 Maple Avenue</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE EDWIN SANDS</b>		4 DATE Pronounced OF DEATH Day Year <b>March 10, 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>3/28/08</b>
9 AGE (In years last birthday) <b>58</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Estimator (Retired)</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Naval Ord. Lab.</b>	
11 BIRTHPLACE (State or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>Yes WW II</b>		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Miss Elizabeth Monmonier, 5129 Rolling Rd.</b>		Address <b>21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b> 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>	
20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		22. DATE SIGNED <b>March 10, 1967</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>3/15/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d LOCATION (City or town) (County) (State) <b>Montgomery Balto. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25a REC'D BY REGISTRAR <b>MAR 17 1967</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

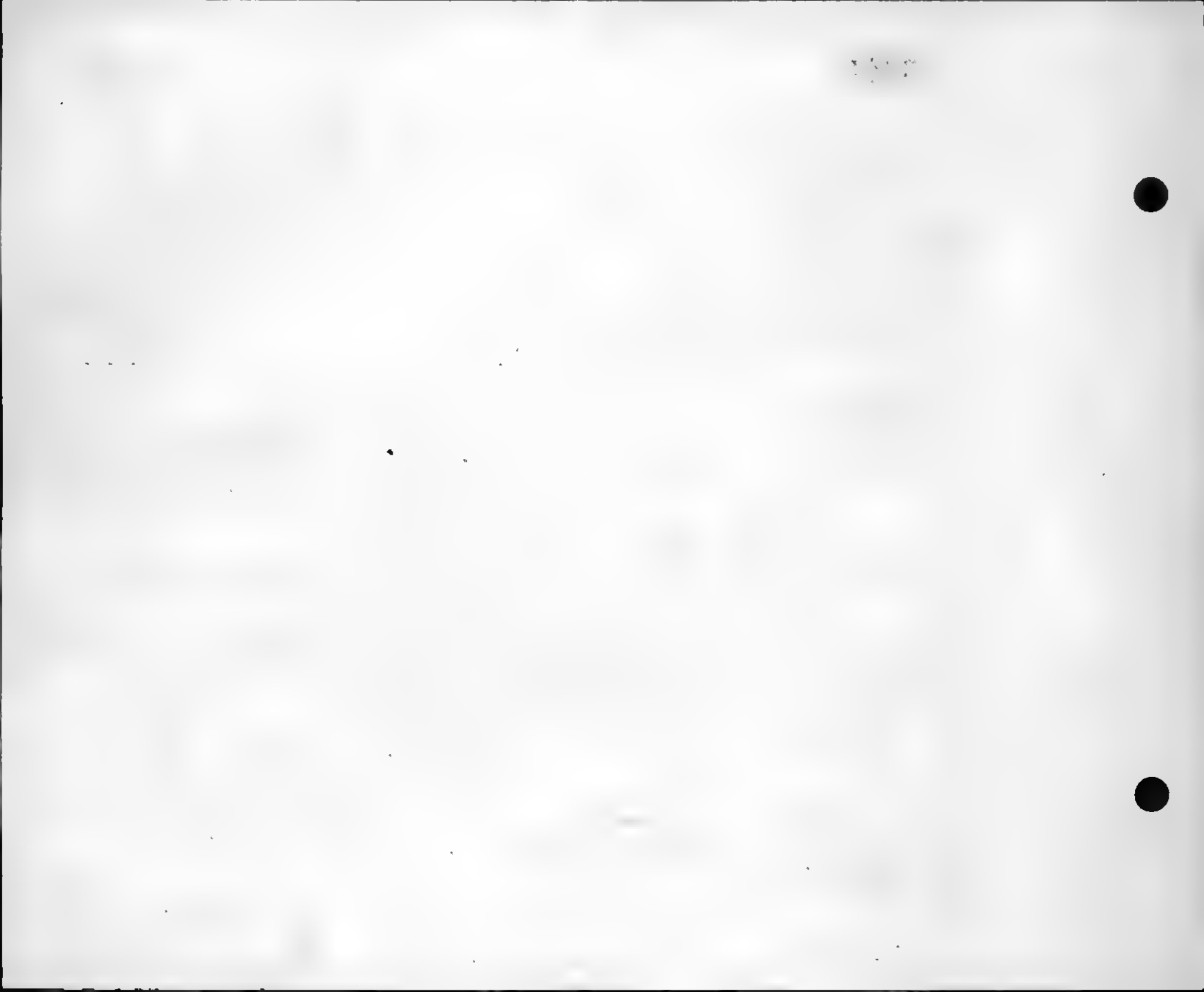
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03939

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d. STREET ADDRESS <u>1013 Ruatan St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>a.</u> Last <u>Saunders</u>		4 DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>49</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>telephone operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CoP telephone Co.</u>	11 BIRTHPLACE (State or foreign country) <u>Pa.</u>
13 FATHER'S NAME <u>Andrew Gargano</u>		14. MOTHER'S MAIDEN NAME <u>Antoinette Giodano</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>578-03 0862</u>	17 INFORMANT <u>Roy J. Saunders</u> Address <u>1013 Ruatan Street Adelphi, Maryland</u>
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Insufficiency Acute.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Right Cardiac Failure.</u> (c) <u>Hypertensive Cardio Vascular Disease.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> years.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>3/5/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		Address (Street, city, town, or county) <u>7936 Old Georgetown Rd. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hyattsville, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

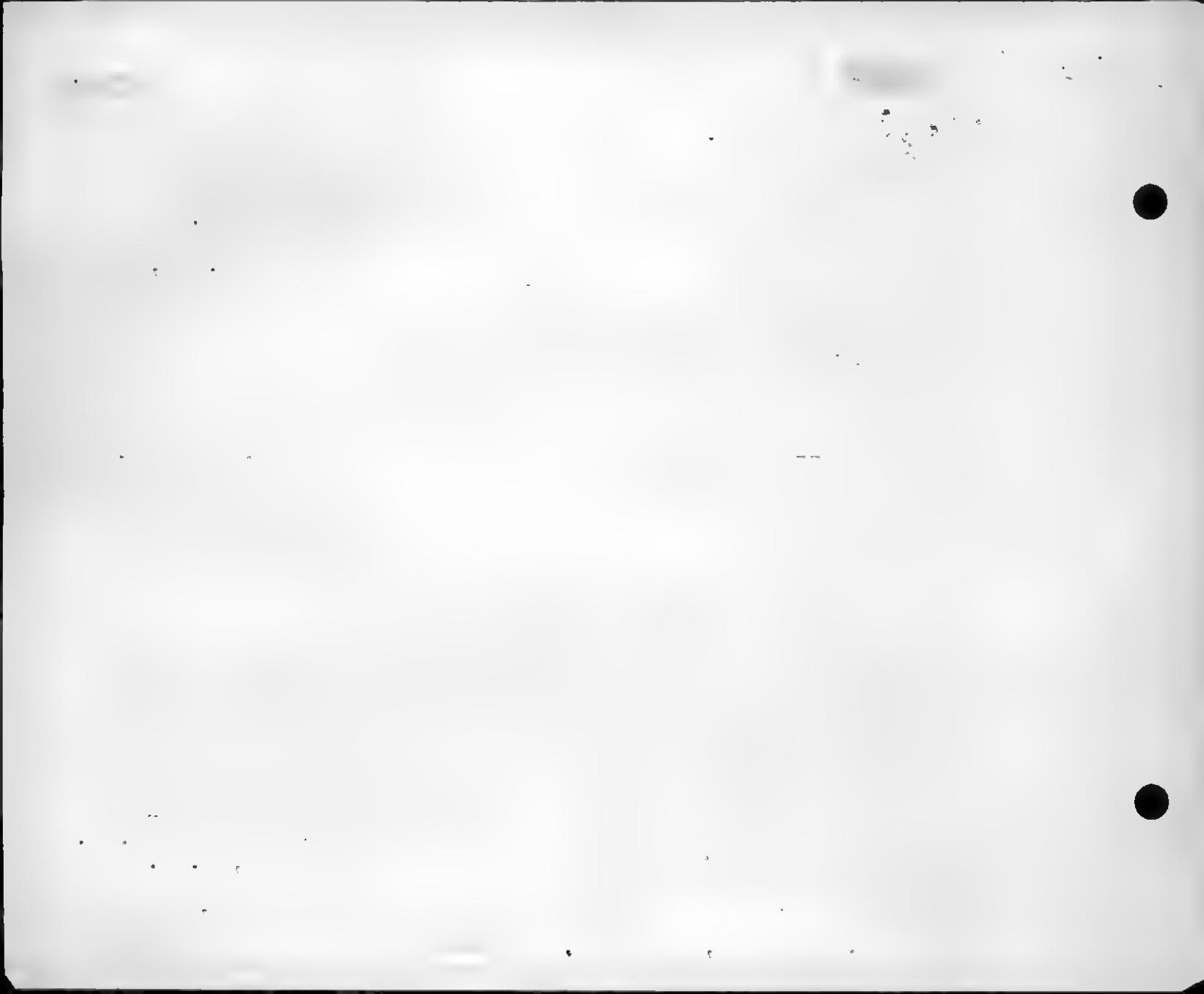
**CERTIFICATE OF DEATH**

**03942**

**03940**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		d. STREET ADDRESS <b>7906 MacArthur Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>HUGO</b> Middle <b>SCHMIDT</b> Last		4. DATE OF DEATH Month <b>Mar.</b> Day <b>12,</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1900</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Iron Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Franklin County, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE SCHMIDT</b>		14. MOTHER'S MAIDEN NAME <b>MARY KUNTZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-01-2705</b>	
17. INFORMANT <b>Ethel Compton</b>		Address <b>653 N. High St. Ohio</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> <b>177X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>November, 1965</b> , to <b>March, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 11, 1967</b> , and that death occurred at <b>3:40 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Hamilton P. Dorman</i>		22b. DATE SIGNED <b>3-12-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HAMILTON P. DORMAN</b>		22d. ADDRESS <b>1302 - 18th St., N. W. Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Methodist Cem.</b>	23d. LOCATION (City or town) (County) (State) <b>Potomac, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 16 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

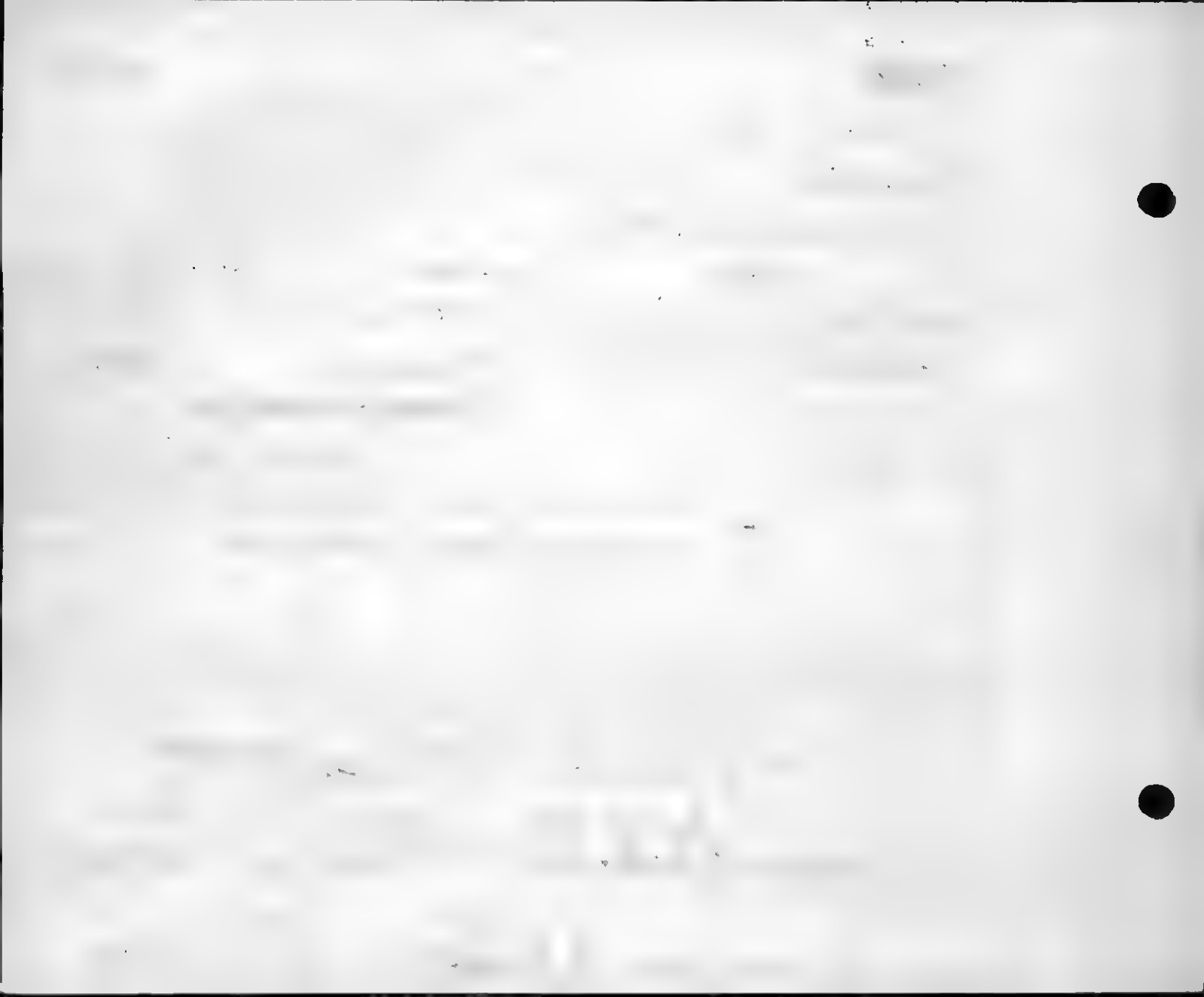
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03943

CERTIFICATE OF DEATH

03941

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
c. LENGTH OF STAY IN 1b <u>1 yr 4 mos</u>		d. STREET ADDRESS <u>3040 IDAHO AVE., N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL HALL SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HILDA (NMI) SCHWEIZER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 5 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BERNARD SWITZER</u>		14. MOTHER'S MAIDEN NAME <u>FANNY SCHWARTZCHILD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>MRS. MALVINA BALOGH</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, oropharynx</u> Conditions, if any, which gave rise to immediate cause (b) <u>cerebral arterial thrombosis</u> stating the underlying cause last. (c) <u>ASCVD</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>—</u> to <u>THE PRESENT</u> , that (I) (we) last saw the deceased alive on <u>2-26 1967</u> , and that death occurred at <u>100 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Youngblood</u> M.D.		22b. DATE SIGNED <u>3-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD</u>		22d. ADDRESS <u>WASHINGTON CLINIC, WASHINGTON, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>3/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREM.</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>
24. FUNERAL DIRECTOR <u>JOSEPH GAVLER'S SONS, INC.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>1967</u>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**03944**

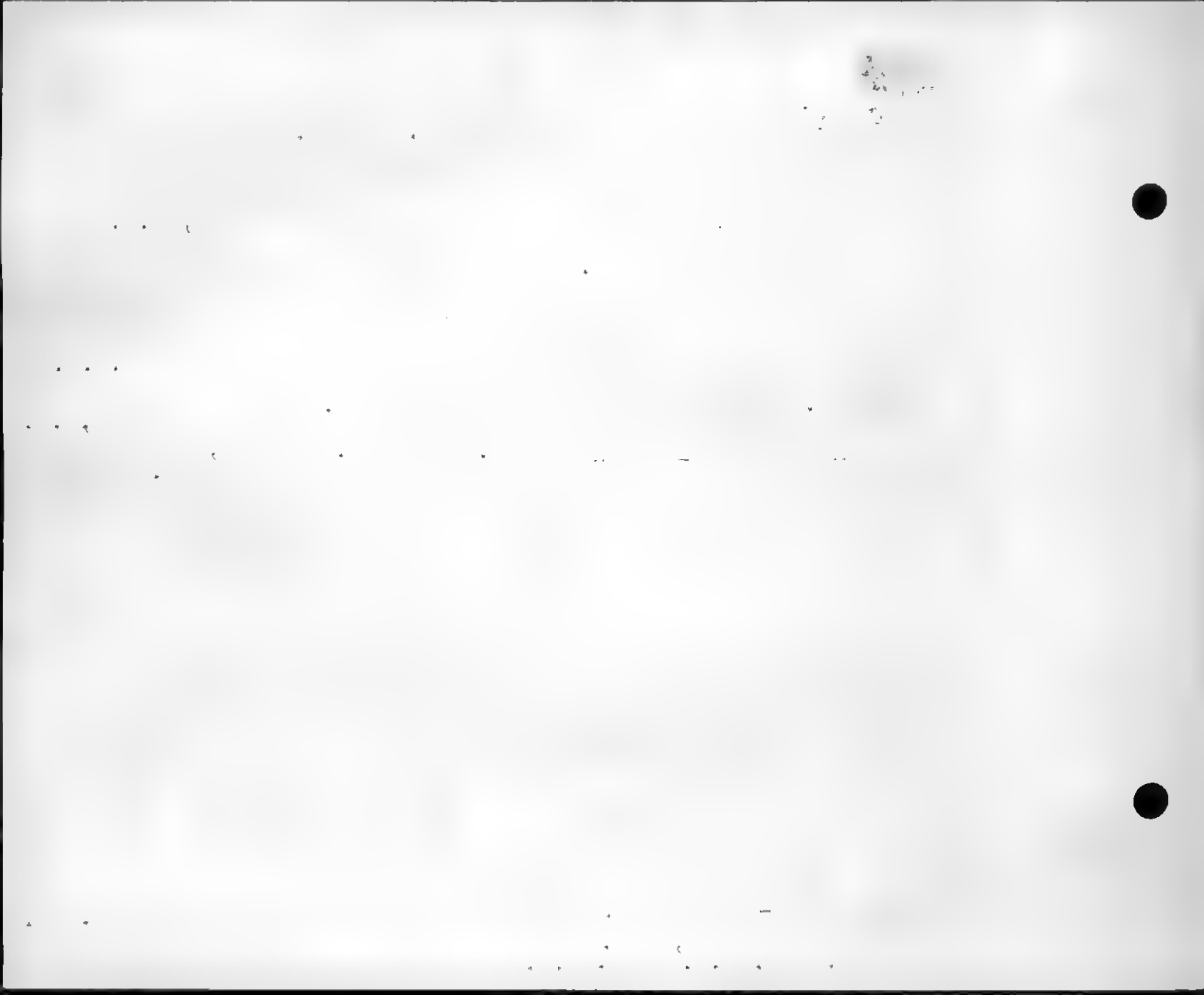
**CERTIFICATE OF DEATH**

**03942**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>Washington</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY <b>- - -</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3701 Connecticut Ave, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>NORA J. SHALLCROSS</b>		4 DATE OF DEATH Month Day Year <b>Mar 29 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3-3-1879</b>
9 AGE (In years last birthday) <b>88 yrs.</b>		10 IF UNDER 1 YEAR Months Days Hours Min <b>29 00 00 00</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Internal Revenue/ Maryland</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>William H. Rabbitt</b>		14 MOTHER'S MAIDEN NAME <b>Lucy J. Davis</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>- - - - -</b>	
17 INFORMANT <b>Mrs. Outram W. Sherman</b>		Address <b>Mahopac, N.Y. Bullet Hole Rd.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 4000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-1</b> , 19 <b>67</b> , to <b>3-29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-29</b> , 19 <b>67</b> , and that death occurred at <b>6<sup>00</sup> AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert Kramer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT KRAMER</b>		22d. ADDRESS <b>8484 16<sup>th</sup> ST. S.S. Nd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-1-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>
24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
25b. ADDRESS <b>5130 Wisc. ve. N.W. Wash. D.C.</b>		25c. DATE <b>APR 3 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03945			CERTIFICATE OF DEATH				03943		
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY in it <b>79 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fayetteville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, NIH, Bethesda, Md.</b>					d. STREET ADDRESS <b>(No street address)</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Audrey</b> Middle <b>Glendon</b> Last <b>Shockey</b>					4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>19 67</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 September 1908</b>		9. AGE (In years lost birthday) <b>58 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Parkinson McClung</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Bragg</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>The Medical Records, The Clinical Center, National Institutes of Health, Bethesda, Md.</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Agnogenic myeloid metaplasia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>  <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3 January, 19 67</b> , to <b>23 March, 19 67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>23 March 19 67</b> , and that death occurred at <b>12:25 PM</b> from causes and on the date stated above.									
22a. SIGNATURE <b>Martin H. Cohen</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>24 March 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Martin H. Cohen, M.D.</b>					22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>3-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <b>Fayetteville, W Va</b>			
24. FUNERAL DIRECTOR <b>Frogus 389 N. I. Ave. N.W. Wash. D.C.</b>					25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

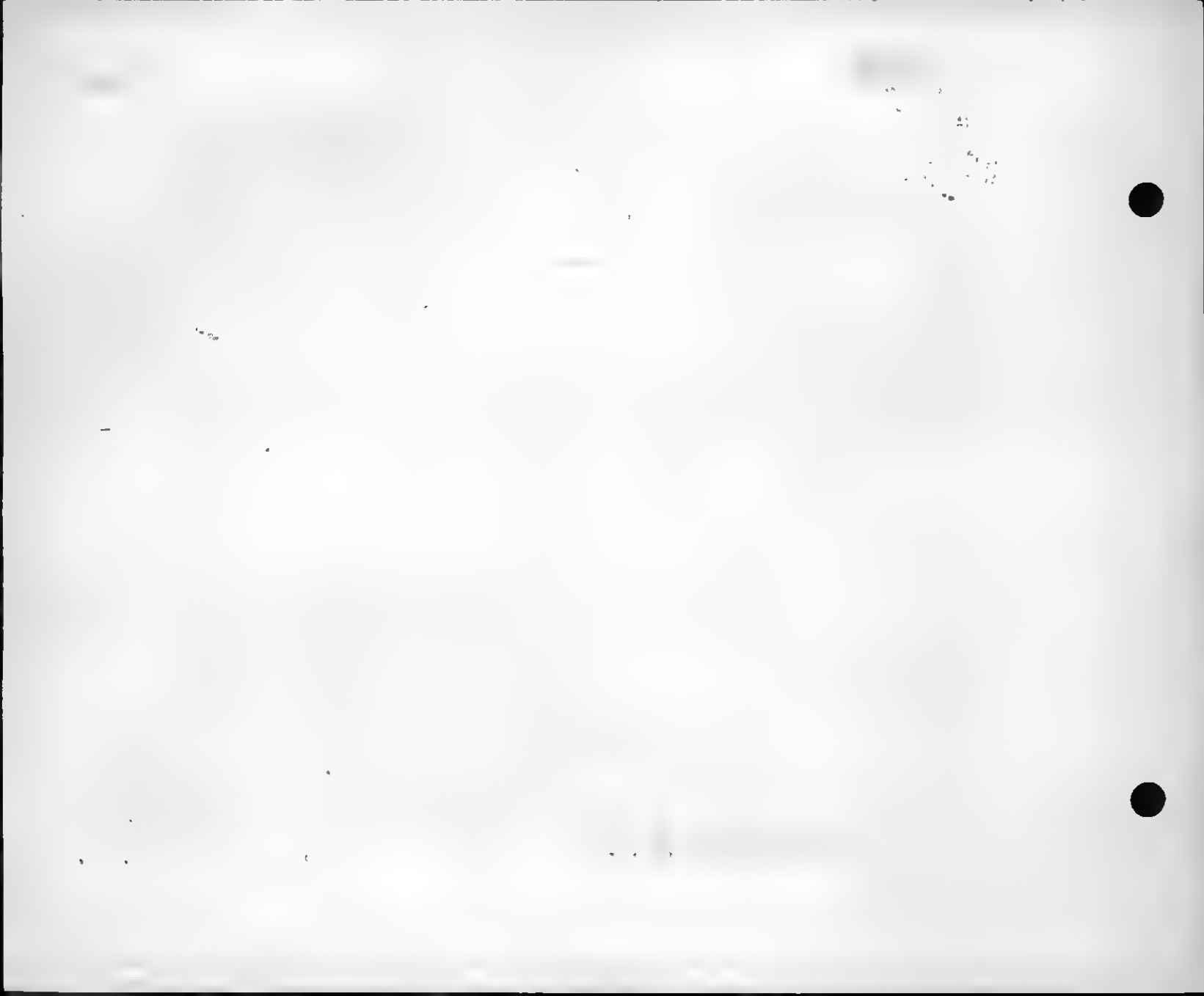
1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3346

CERTIFICATE OF DEATH

03944

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN IT <b>-1 DAY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAMASCUS</b> d. STREET ADDRESS <b>25119 OAK DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>TIRZAH</b> Last <b>SHOOK</b>		4 DATE OF DEATH Month <b>3</b> Day <b>6</b> Year <b>1967</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <b>75</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE, RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOMER</b>	11 BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>
13. FATHER'S NAME <b>JACOB GROVE</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>182-36-4964</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure - due to Arterio-</b> DUE TO <b>sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b>		17. INFORMANT Address <b>Richard D. Shook</b> <b>Damascus, Md.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Embolus to right brachial artery</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>Jan. 1, 1967</b> , to <b>3-6, 1967</b> , that (I) (we) last saw the deceased alive on <b>3-6, 1967</b> , and that death occurred at <b>1 P. M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Jack Schumacher</b> M.D.		22b. DATE SIGNED <b>3-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M.D.</b>		22d ADDRESS <b>RUSSELL AVENUE, GAITHERSBURG, MD.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<b>Burial</b>	<b>3/9/67</b>	<b>Whitemarsh Memorial Park -</b>	<b>Respectville, PA.</b>
24 FUNERAL DIRECTOR	ADDRESS		25a REC'D BY REGISTRAR DATE
<b>A. E. Munnich -</b>	<b>Greencastle, Pa.</b>		<b>MAR 9 1967</b>
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



CERTIFICATE OF DEATH

3947

03945

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN IS <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>8809 Loenard Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Tzvi Silver</b>		4. DATE OF DEATH <b>March 6 1967</b>	
5 SEX <b>Male</b> 6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>March 30 1965</b>	
9. AGE (n years last birthday) <b>1 yrs</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mendel M. Silver</b>		14. MOTHER'S MAIDEN NAME <b>Malka Harendorf</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Father</b>		Address <b>Mr. Mendel M. Silver-as above-2d</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO (b) <b>CEREBRAL ANOXIA</b> DUE TO (c) <b>ACUTE EPICARDITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/25</b> , 19 <b>67</b> , to <b>3/6</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>3/6</b> , 19 <b>67</b> , and that death occurred at <b>3:04</b> A.M., from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. George Cohen</b>		22b. DATE SIGNED <b>3/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. George Cohen</b>		22d. ADDRESS <b>9919 Georgia Avenue, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL Specify <b>Burial</b>		23b. DATE THEREOF <b>3/6/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National Cap. Hebrew Cem. Washington, D.C.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>B. Banzansky &amp; Sons 3501-14th St NW</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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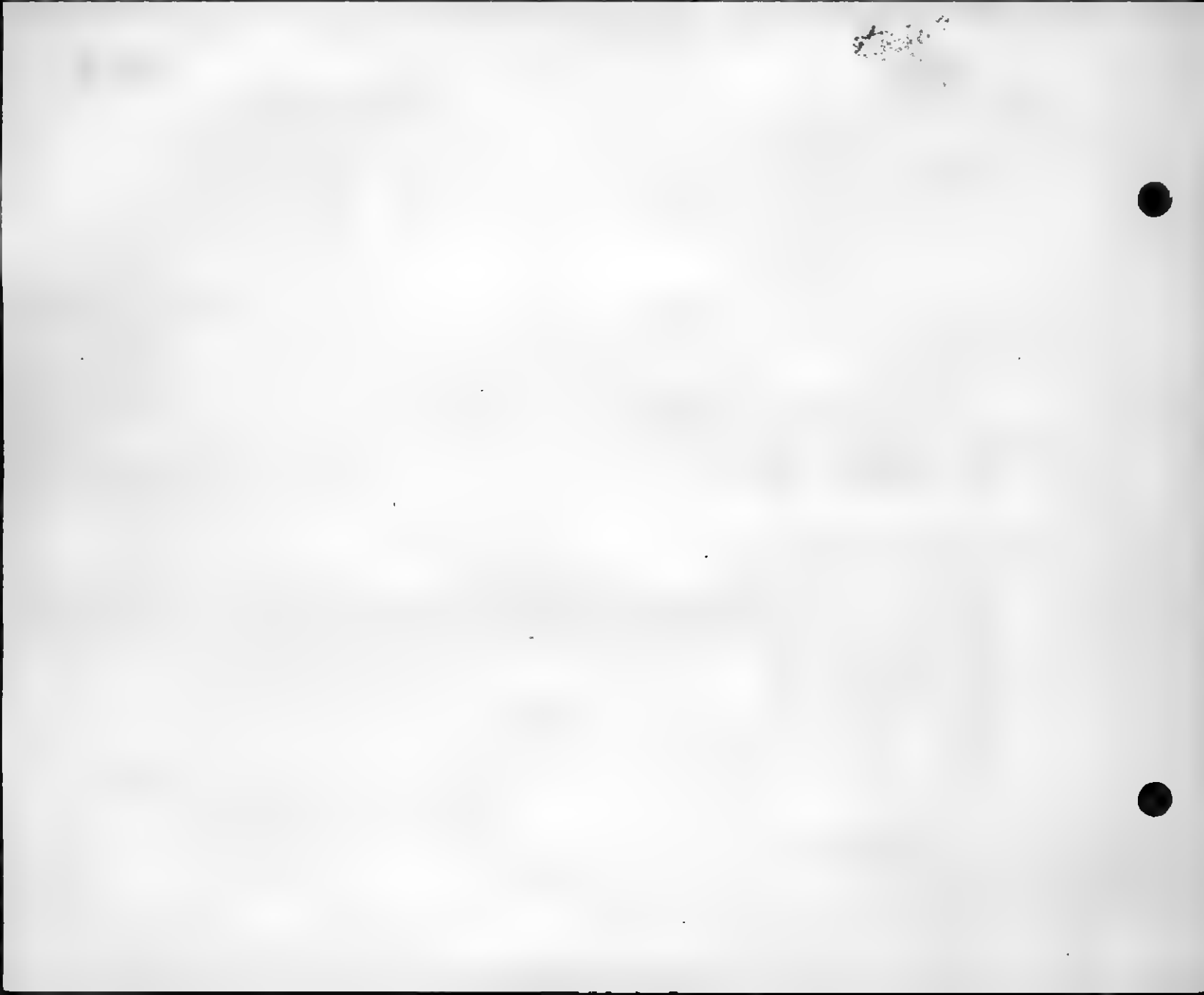
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03948

CERTIFICATE OF DEATH

03946

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>5 Mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8039 EASTERN AVE</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>151</u>	
3. NAME OF DECEASED (Type or print) <u>LILLIE SILVERSTEIN</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-91</u>
9 AGE (In years last birthday) yrs <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>HW</u>		11 BIRTHPLACE (County & State, or foreign country) <u>POLAND, WARSAW</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>ABRAHAM MEYER</u>	
14 MOTHER'S MAIDEN NAME <u>MECHLA</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. <u>219 370291</u>		17 INFORMANT (DAUGHTER) Address <u>MILDRED SILVERSTEIN SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> DUE TO <u>4x01</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CEREBRAL VASCULAR ACCIDENT</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>1-3</u> , 19 <u>67</u> , to <u>3-25</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>3-15</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard H. Ostrow</u> M.D.		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD H OSTROW</u>		22d ADDRESS <u>8107 EASTERN AVE. S.S., MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/26/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24 FUNERAL DIRECTOR <u>SYLVEAN S. LEWIS &amp; SON, INC. GARRISON, MI</u>		25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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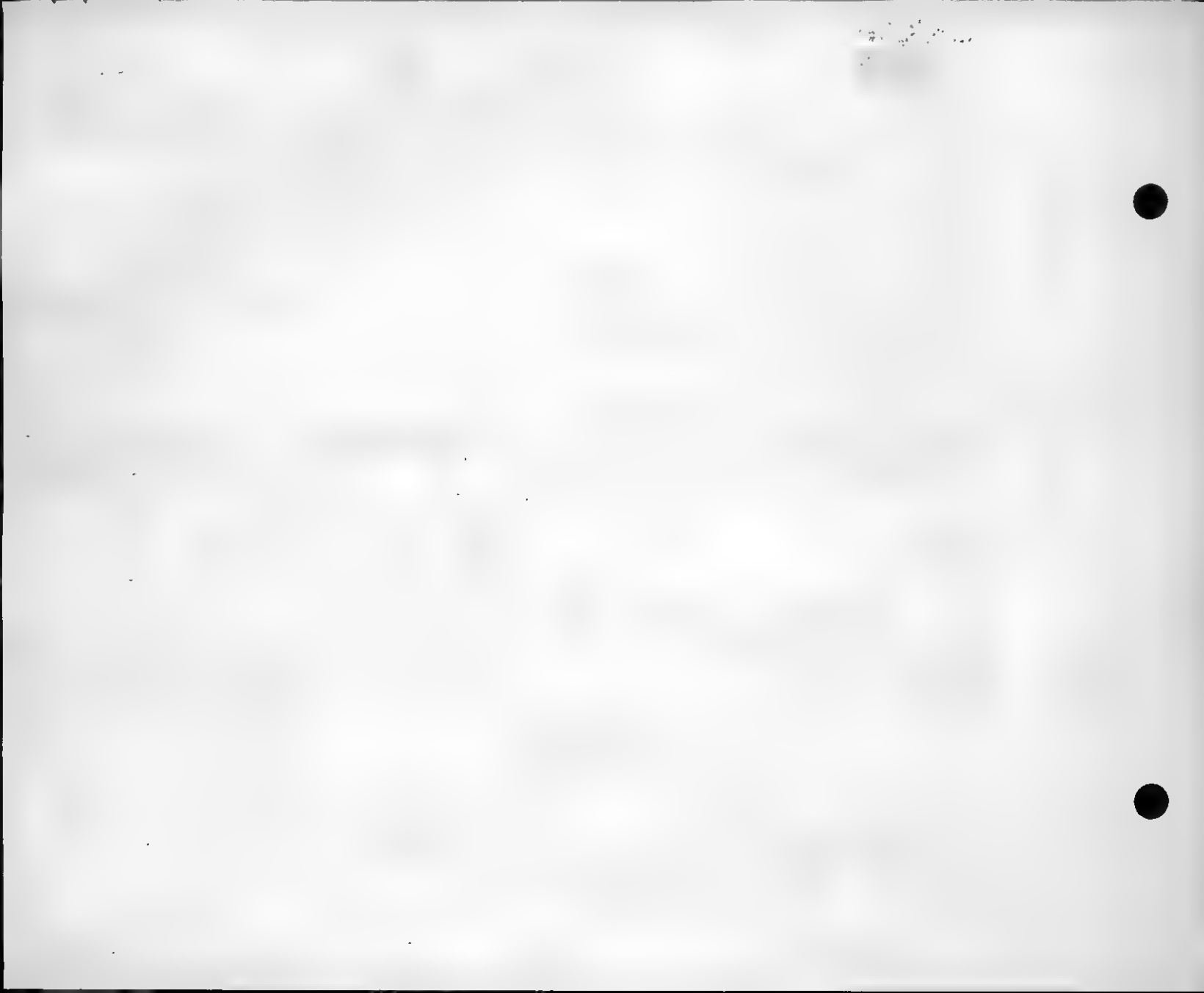
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03949

CERTIFICATE OF DEATH

03947

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ADELPHI</b> d. STREET ADDRESS <b>1821 ELTON RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>ESTHER</b> First <b>NOBLE</b> Middle <b>SMALL</b> Last 5 SEX <b>FEM</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4 DATE OF DEATH <b>MARCH</b> 21 1967 9. AGE (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR: Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSW</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland, DC</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert BURGDOFF</b>		14. MOTHER'S MAIDEN NAME <b>SARAH CASTLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO <b>578-07-1788-A</b> 17. INFORMANT <b>John Sidus</b> Address <b>1821 Elton Rd. Adelphi, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure, Uremia</b> DUE TO (b) <b>Hypertensive cardio-vascular disease</b> DUE TO (c) <b>Essential hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <b>several months</b> <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of breast, Uremia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>3-16</b> , 1967, to <b>3-21</b> , 1967, that (1) (was) last saw the deceased alive on <b>3-21</b> , 1967, and that death occurred at <b>10:15</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Eino Magi</b>		22b. DATE SIGNED <b>3-21-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EINO MAGI</b>		22d. ADDRESS <b>831 University Blvd. E., Silver Spring</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 24, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Glen Carter</b> ADDRESS <b>4434 Georgia Avenue</b> <b>Warner E. Pumphrey, Inc.</b> <b>Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03950

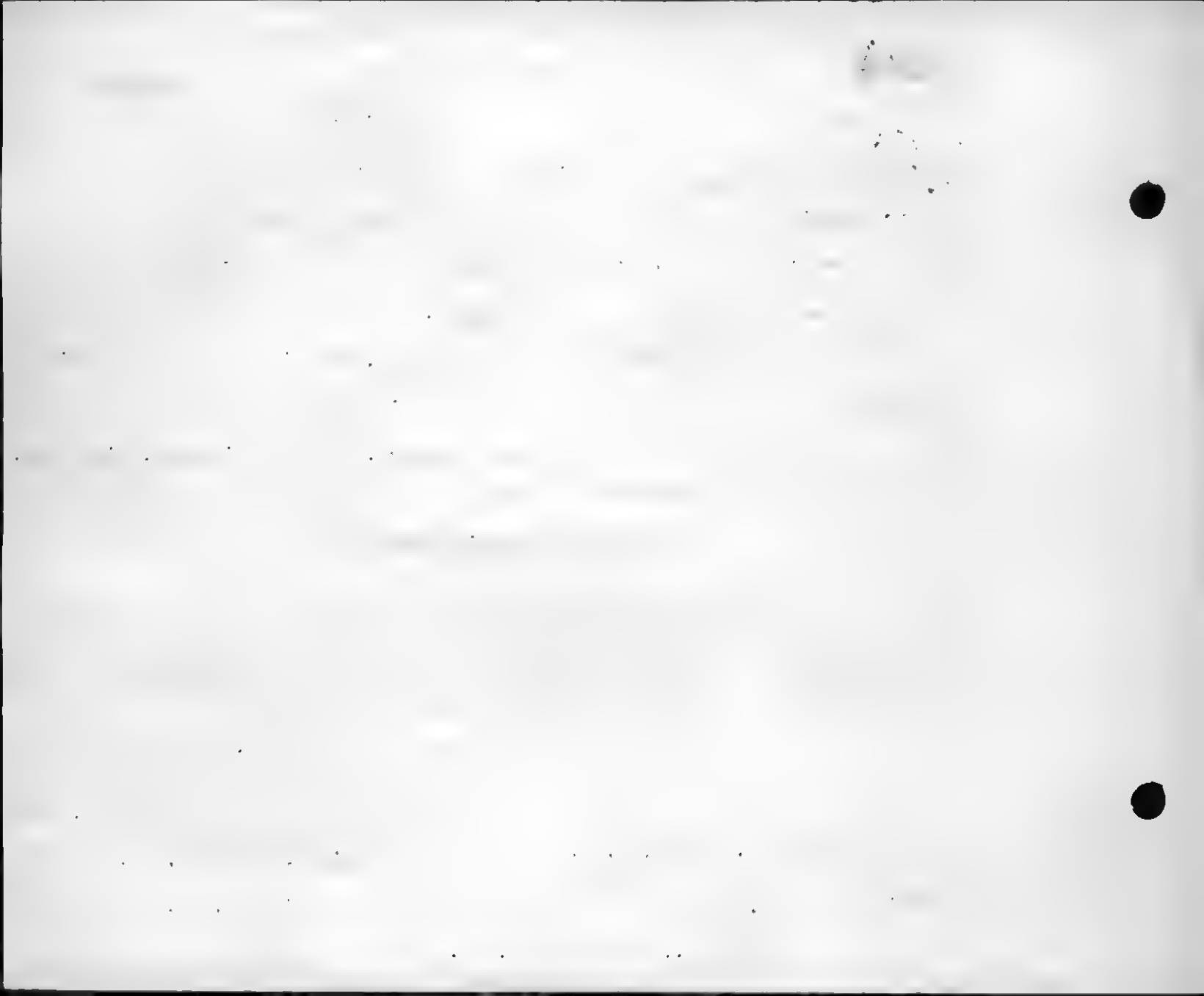
CERTIFICATE OF DEATH

03948

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN TB <b>9 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna</b>		d. STREET ADDRESS <b>2533 Rambling Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kenneth</b> Middle <b>James</b> Last <b>SMALMAN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1959</b>
9. AGE (In years last birthday) yrs. <b>7</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Honolulu, Hawaii</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Smallman</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>John Smallman, 2533 Rambling Road, Vienna, Va.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tetralogy of Fallot</b> DUE TO (b) <b>Congenital malformation heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 14</b> , 19 <b>67</b> , to <b>March 23</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 23</b> , 19 <b>67</b> , and that death occurred at <b>215A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Donald H. Gaylon</i> M.D.		22b. DATE SIGNED <b>March 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald H. Gaylon, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 27, 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>
24. FUNERAL DIRECTOR <b>Falls Church Funeral Home, 1102 West Broad St., Falls Church, Va.</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



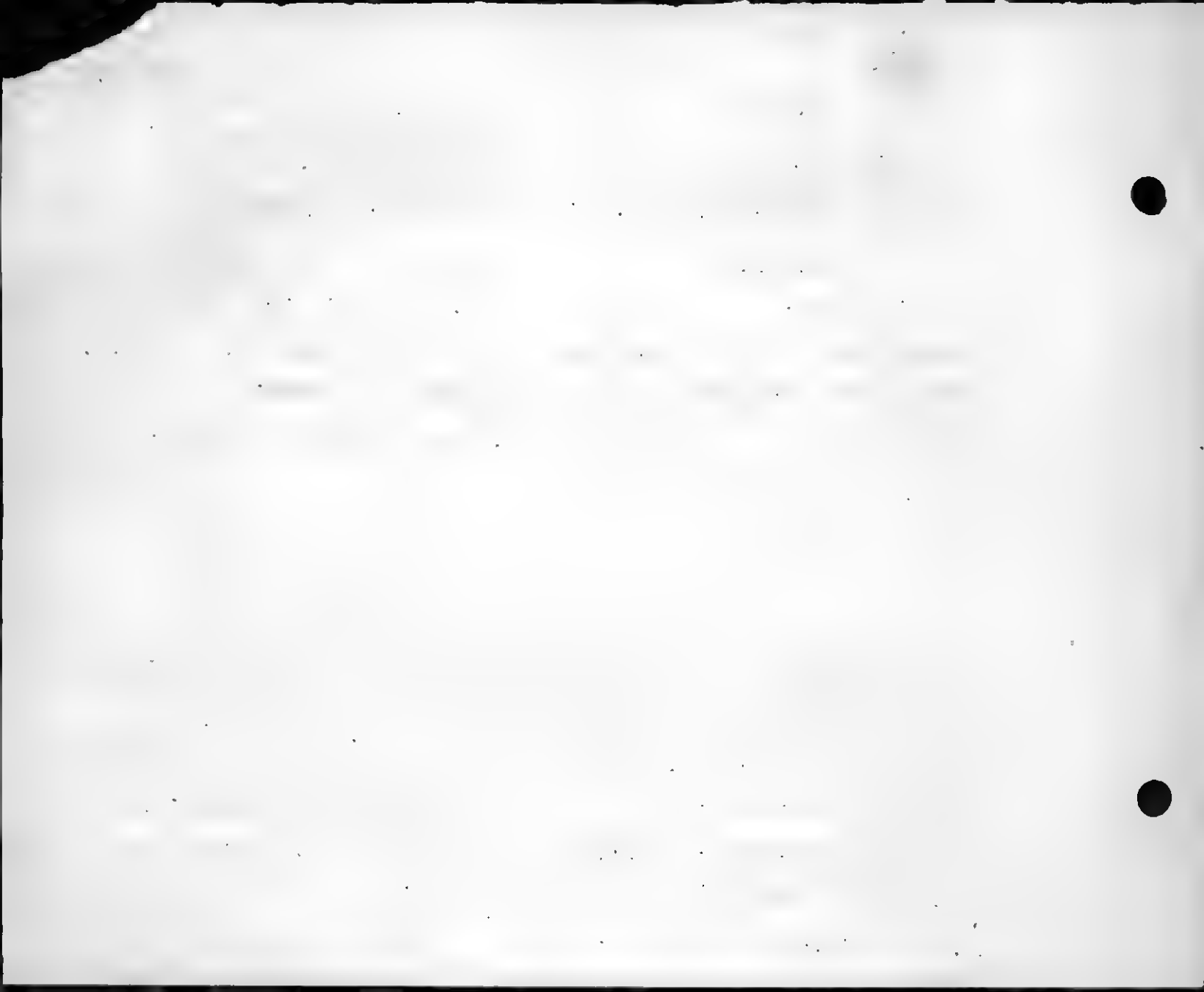
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**03951** **CERTIFICATE OF DEATH** **03949**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK.</b> d. STREET ADDRESS <b>7205 SPRUCE AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>MAE</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>25</b> Year <b>19 67.</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1887</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>15-1</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Howard County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Albert Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Holtman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>	
17. INFORMANT <b>H. Elmer Shipley, (same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast</b> DUE TO (b) <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 9, 1967</b> to <b>Mar 24, 1967</b> , that (I) (we) last saw the deceased alive on <b>Mar. 24, 1967</b> , and that death occurred at <b>12:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Theodore R. Flaiz</b>		22b. DATE SIGNED <b>9/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>THEODORE R. FLAIZ</b>		22d. ADDRESS <b>7030 CARROLL AVENUE, Tak Pk. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Switzland, Pa. Geo. Co. Md.</b>
24. FUNERAL DIRECTOR <b>J. Arthur Walters</b>		25. REC'D BY REGISTRAR <b>258 MAR 28 1967</b>	
ADDRESS <b>254 Carroll St. N.W.D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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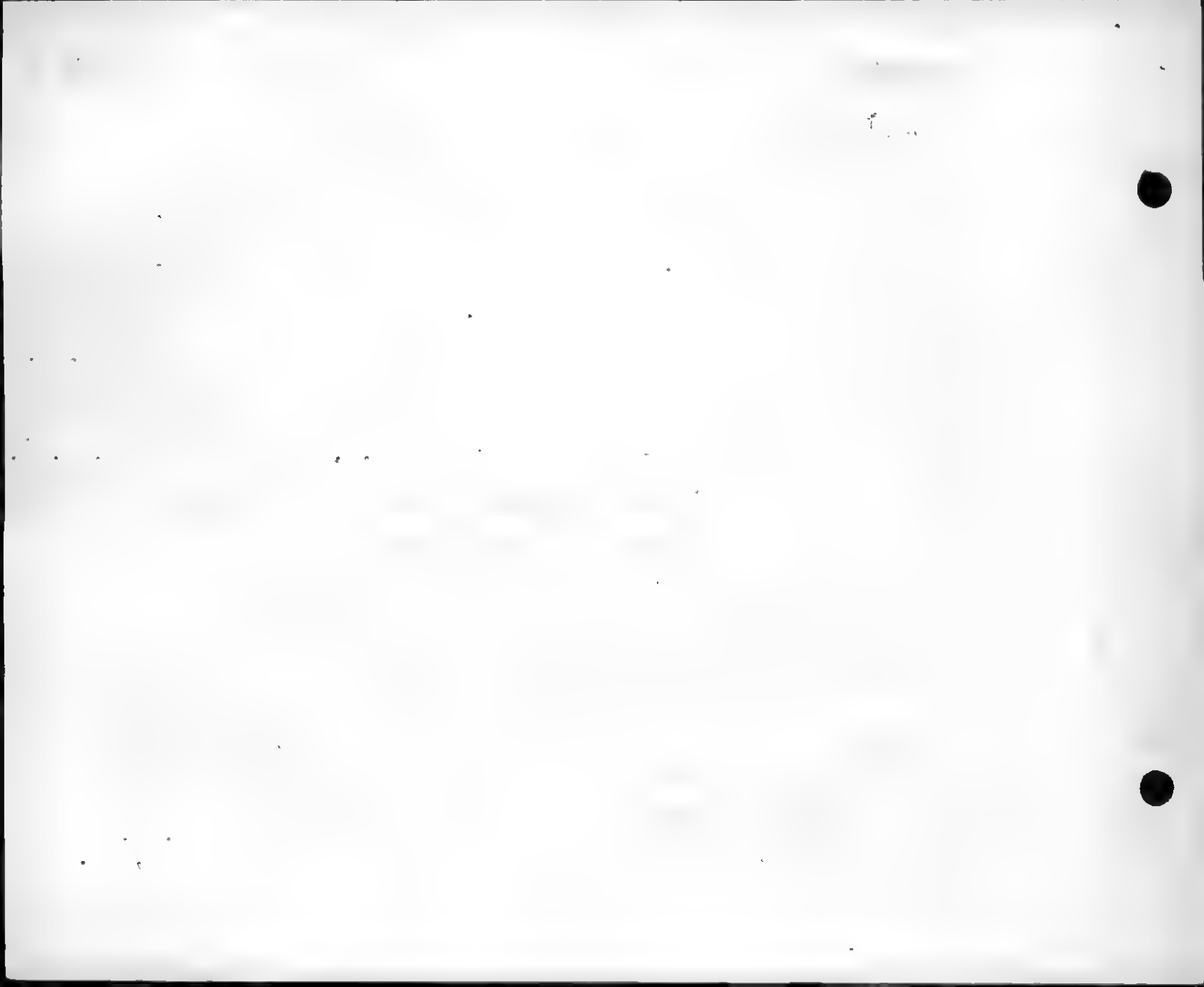
FOR STATE  
HEALTH DEPT.

03952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03950

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c LENGTH OF STAY IN 1b <b>2 Months</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens Nursing Home</b>		d STREET ADDRESS <b>14326 New Hampshire Ave.</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>MAETIE P. SMITH</b>		4 DATE OF DEATH Month Day Year <b>March 1, 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 15, 1874</b>
9 AGE (in years last birthday) <b>92</b>		f UNDER 1 YEAR Months Days <b>19</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <b>Ohio</b>
12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13 FATHER'S NAME <b>Ferdinand Prohl</b>	
14 MOTHER'S MAIDEN NAME <b>Christine Stettner</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>578-62-5056</b>		17 INFORMANT <b>Son</b> <b>Frederick A.B. Smith, Washington, D. C.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma metastatic of lungs + abdomen.</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Rt. Breast.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 Months?</b> <b>2 Years?</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		22. DATE SIGNED <b>Mar. 2, 1967</b> Address (Street, city, town, or county) <b>Bethesda, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b DATE THEREOF <b>3-2-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d LOCATION (City or town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a REC'D BY REGISTRAR <b>MAR 8 1967</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03951

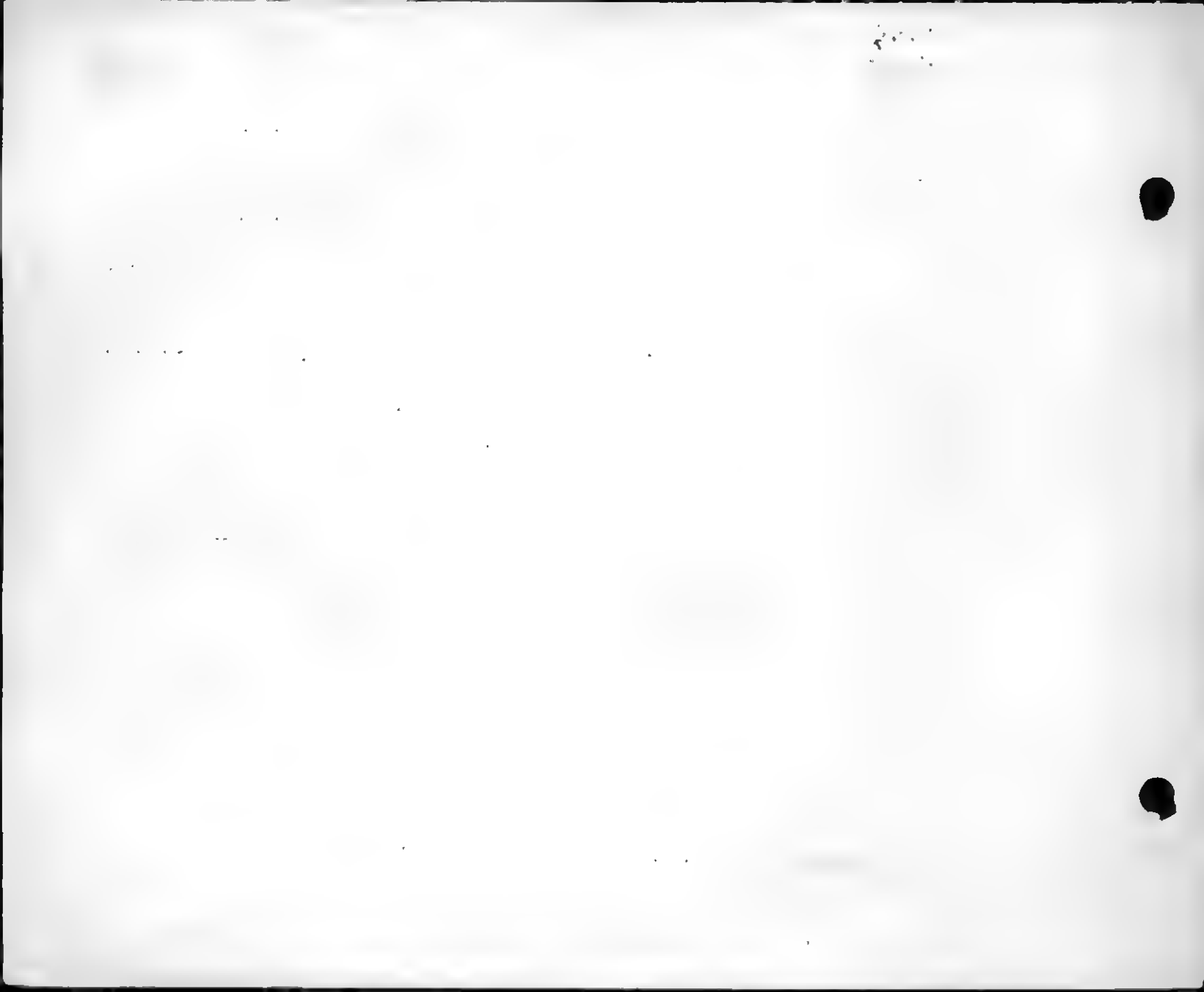
FOR STATE  
HEALTH DEPT

03953

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f. institution Residence before adm'ssion) a. STATE <b>Washington D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN b <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>		d. STREET ADDRESS <b>4541 45th Street N. W.</b>	
3 NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>PAULINE</b> Last <b>SMITH</b>		4 DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>89</b>
9 AGE (In years birth day) <b>89</b>		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
11 USUAL OCCUPATION (Give kind of work done during week before death, even if retired) <b>Housewife</b>		12 BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13 FATHER'S NAME <b>Unknown</b>		14 MOTHER'S MAIDEN NAME <b>Unknown</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give branch or unknown) <b>no</b>		16 SOCIAL SECURITY NO. <b>none</b>	
17 INFORMANT <b>Mrs. Ethel Ayers</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden Reap</b> M.D.		22. DATE SIGNED <b>3/30/67</b>	
EXAMINER'S NAME (Type) <b>Belden Reap M. D.</b>		23. NAME OF CEMETERY OR CREMATORY <b>Greenhill</b>	
23a. BURIAL, CREMATION, or other (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/67</b>	
24 FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>		25. REC'D BY REGISTRAR <b>APR 3 1967</b>	
26. LOCATION (City or town) (County) (State) <b>Martinsburg West Virginia</b>		27. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

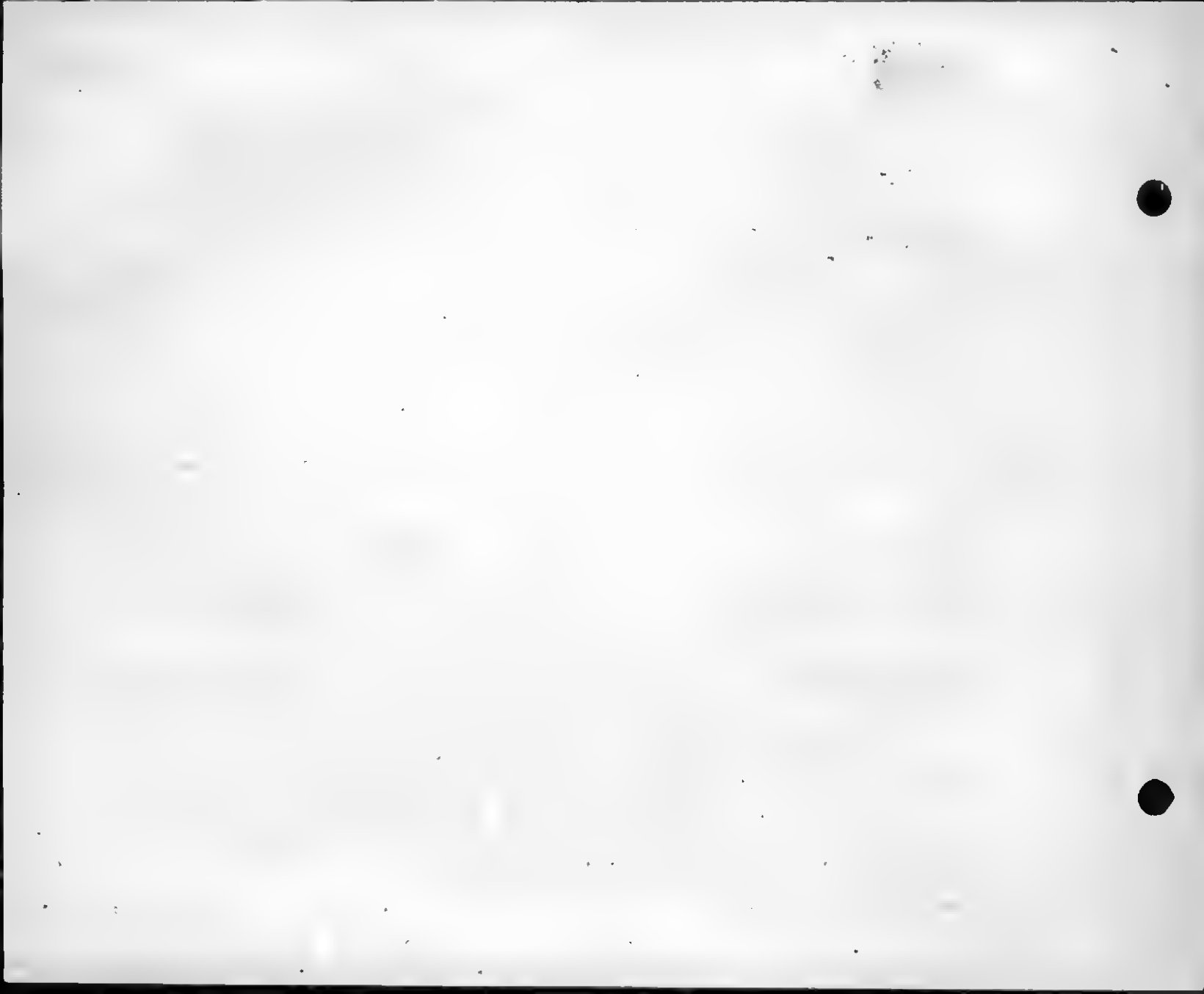
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03954

# CERTIFICATE OF DEATH

03952

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Michigan</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>37 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grant</b> 512		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>			d. STREET ADDRESS <b>No Street Address</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mildred Elaine Smith</b>			4. DATE OF DEATH <b>March 22 19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 March 1908</b>	9. AGE (In years last birthday) <b>59</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse's Aide</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>	
13. FATHER'S NAME <b>Al Blood</b>			14. MOTHER'S MAIDEN NAME <b>Claudia Finley</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>378-38-6001</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blastic crisis</b> 2041 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myelogenous leukemia</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1-1/2 months</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)		
21. I certify that <del>HE</del> (this hospital) attended the deceased from <b>13 Feb.</b> , 1967, to <b>22 March</b> , 1967, that (I) (we) last saw the deceased alive on <b>22 March</b> , 1967, and that death occurred at <b>9:05</b> M, from causes and on the date stated above.					
22a. SIGNATURE <i>I. David Goldman</i> M.D.			22b. DATE SIGNED <b>23 March 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>I. David Goldman, M.D.</b>			22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Burial-transit 3-24-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Center Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Ashland Township, Mich.</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 27 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

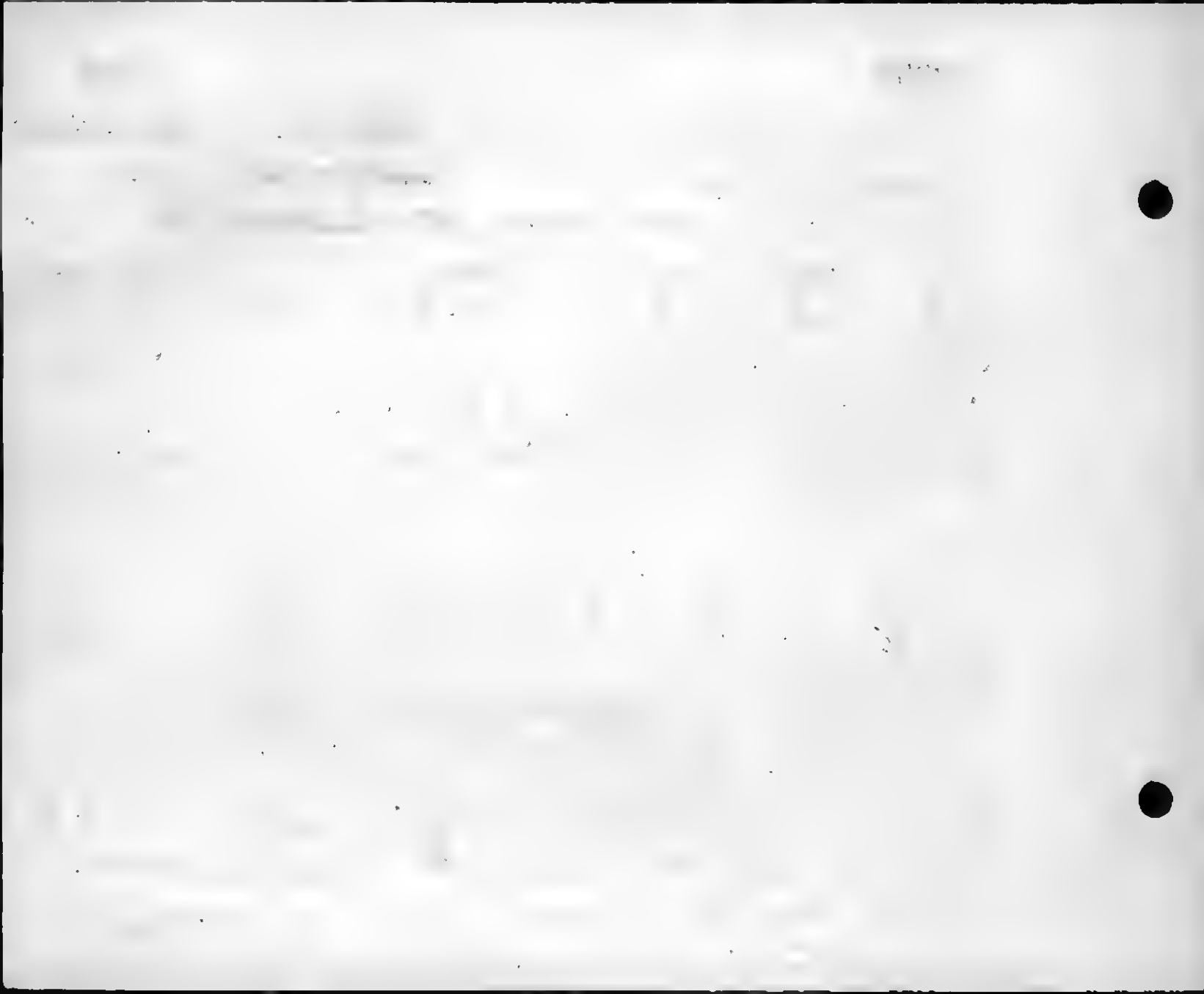
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03955

CERTIFICATE OF DEATH

03953

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <del>XXXXX</del> Penna. b. COUNTY <del>Montgomery</del> <b>Philadelphia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXXXXXXXXX</del> <b>Philadelphia</b>	
c. LENGTH OF STAY IN 1b <b>6 days</b>		d. STREET ADDRESS <b>7222 Glenlock Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SISTERS OF HOLY CROSS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>PAUL Luther SMALL</b>		4. DATE OF DEATH Month Day Year <b>3 - 30 1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-98</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red) <b>RETIRED BRICKLAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bldg. Const.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>LICKDALE, PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>BENNEVILLE SMALL</b>		14. MOTHER'S MAIDEN NAME <b>AMELIA DIETRICH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO <b>Yes</b>	
17. INFORMANT <b>JANE A. STURGES</b>		Address <b>4515 CLEMONT PL. Garrett Bk., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO <b>MEASTATIC CANCER</b> DUE TO <b>BRONCHOGENIC CARCINOMA</b> DUE TO <b>BRONCHOGENIC CARCINOMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>POBULAR PNEUMONIA - DIABETIC HISTORY</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> , 19 <b>67</b> to <b>3/30</b> , 1967, that (I) (we) last saw the deceased alive on <b>3/29</b> , 1967, and that death occurred at <b>8A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Charles Farwell</b>		22b. DATE SIGNED <b>March 30, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles Farwell</b>		22d. ADDRESS <b>11406 Viers Mill Rd. Wheaton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transhumal</b>		23b. DATE THEREOF <b>April 3, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Annuille Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Annuille Lebanon Penna</b>	
24. FUNERAL DIRECTOR <b>Warner &amp; Pumphrey Inc. 8434 Georgia Ave Sil. Spr., Md.</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**03956**

**CERTIFICATE OF DEATH**

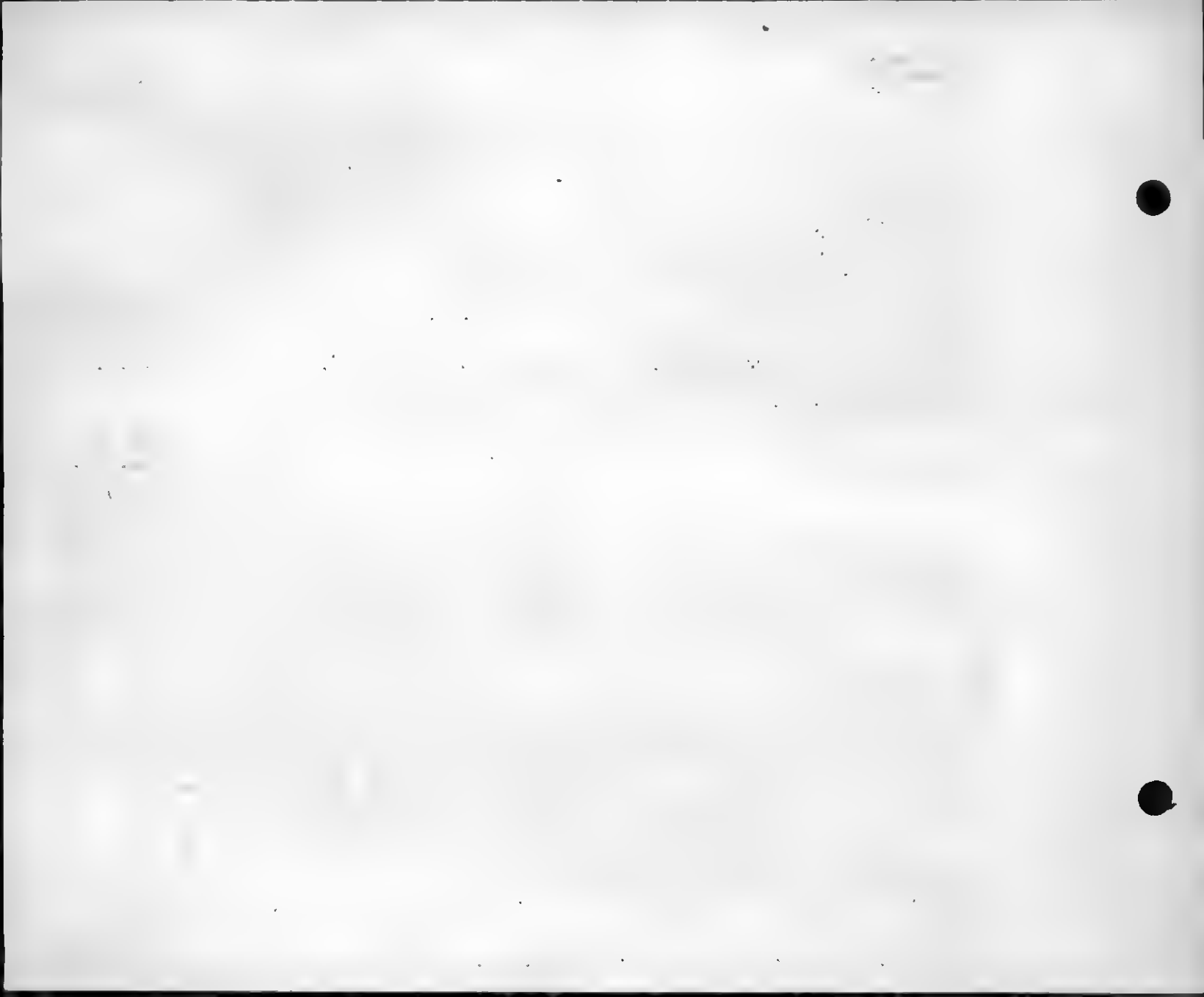
**03956**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> /-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			d. STREET ADDRESS <u>10311 Brookmoor Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lamonte</u> Middle <u>Frederick</u> Last <u>Sonnemann</u>			4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>19 67</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1900</u>		9. AGE (In years last birthday) <u>67</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>	
13. FATHER'S NAME <u>Frederick Sonnemann</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Estelle Jasker</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>Mrs. Lila Sonnemann 10311 Brookmoor Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOGENIC CARCINOMA WITH METASTASES</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>16 21</u> <u>4 YEARS</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EMPHYSEMA</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY, 1963</u> to <u>MARCH 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 7, 1967</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Robert D. Friedman</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>MARCH 7 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>ROBERT H. KRICHMAR</u>			22d. ADDRESS <u>7733 ARABIA AVENUE N.W. WASH. D.C. 20012</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
		23d. LOCATION (City or Town) <u>Rockville, Maryland</u>		(County) (State)	
24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Pumphrey, Inc. Silver Spring, Md.</u>			25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
20 M 1/68



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

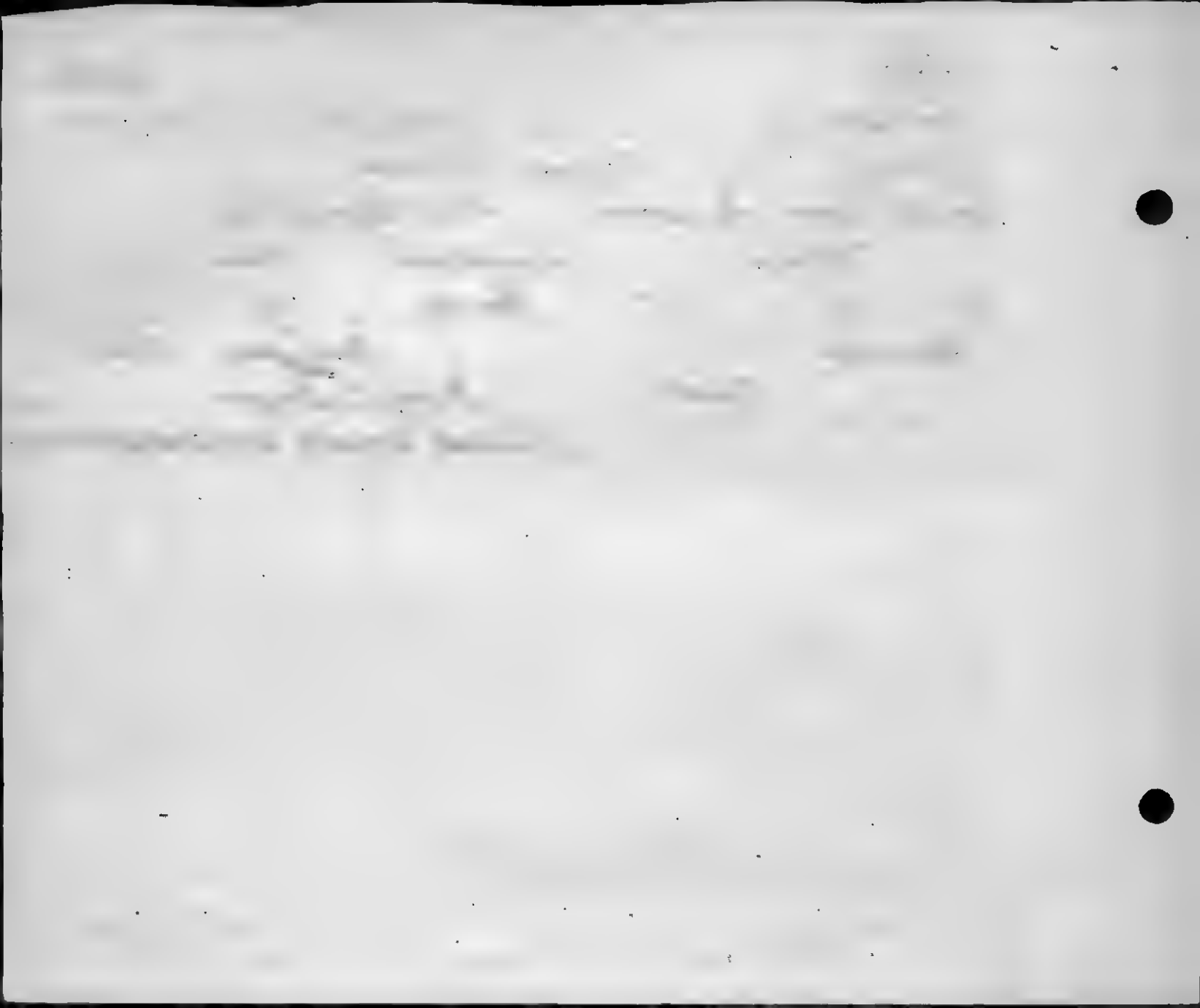
## CERTIFICATE OF DEATH

03957

03955

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>3505 Randolph Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Annie</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>6</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 12, 1868</u>	<b>9. AGE</b> (in years last birthday) <u>98</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Jersey</u>			
<b>13. FATHER'S NAME</b> <u>Hall</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary G. Bayce</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>Edward Wright, 3505 Randolph Rd Wheaton</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> (b) <u>Congestive heart failure</u> (c) <u>old age - terminal bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis, progressive debility</u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____		<b>20g. (County)</b> _____		<b>20h. (State)</b> _____			
<b>21. I certify that (1) (his hospital) attended the deceased from <u>2-12-64</u> to <u>3-6</u>, 1967, that (1) (we) last saw the deceased alive on <u>3-5</u>, 1967, and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>John R. Spencer</u>		<b>22b. DATE SIGNED</b> <u>3-6-67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN R. SPENCER</u>			
<b>22d. ADDRESS</b> <u>BURTONSVILLE, MD.</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input type="checkbox"/> <b>22g. STAFF PHYS.</b> <input type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-9-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Prospect Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Asbury Park, N. Jersey</u>		<b>23e. (State)</b> _____					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		<b>24a. ADDRESS</b> _____		<b>24b. REC'D BY REGISTRAR</b> <u>MAR 10 1967</u>			
<b>24c. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>24d. DATE</b> _____					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

03958

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03958

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Takoma Park</b>				c LENGTH OF STAY IN b <b>15-1</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <b>7511 Carroll Ave</b>				d STREET ADDRESS <b>7511 Carroll Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Cecil</b> Middle <b>Lonnie</b> Last <b>Spears</b> Sr.				4 DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>19 67</b>			
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4-29-12</b>	9 AGE (In years last birthday) <b>55</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cab Driver</b>			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		
13 FATHER'S NAME <b>Everett Spears</b>			14 MOTHER'S MAIDEN NAME <b>Effie</b>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16 SOCIAL SECURITY NO <b>232-18-2380</b>		17 INFORMANT <b>LAWRENCE SPEARS</b> Address <b>ARLINGTON, VA.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <b>4341</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure accompanied by</b> DUE TO (b) <b>markedly fatty liver and obesity</b> DUE TO (c) <b>markedly fatty liver and obesity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.						INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f (City or town)			20g (County)		20h (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b DATE THEREOF <b>4-4-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>BRANCHLAND CEMETERY</b>		
24 FUNERAL DIRECTOR <b>LIVES FUNERAL HOME</b> by: <b>Ben E. Rogers, Jr.</b>			24a ADDRESS <b>2847 W. Isom Blvd</b> <b>ARLINGTON, VA.</b>		24b REC'D BY REGISTRAR <b>APR 4 1967</b>		
25 REGISTRAR'S SIGNATURE <b>Charles Judge</b>			25a ADDRESS <b>3/30/1967</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to your papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

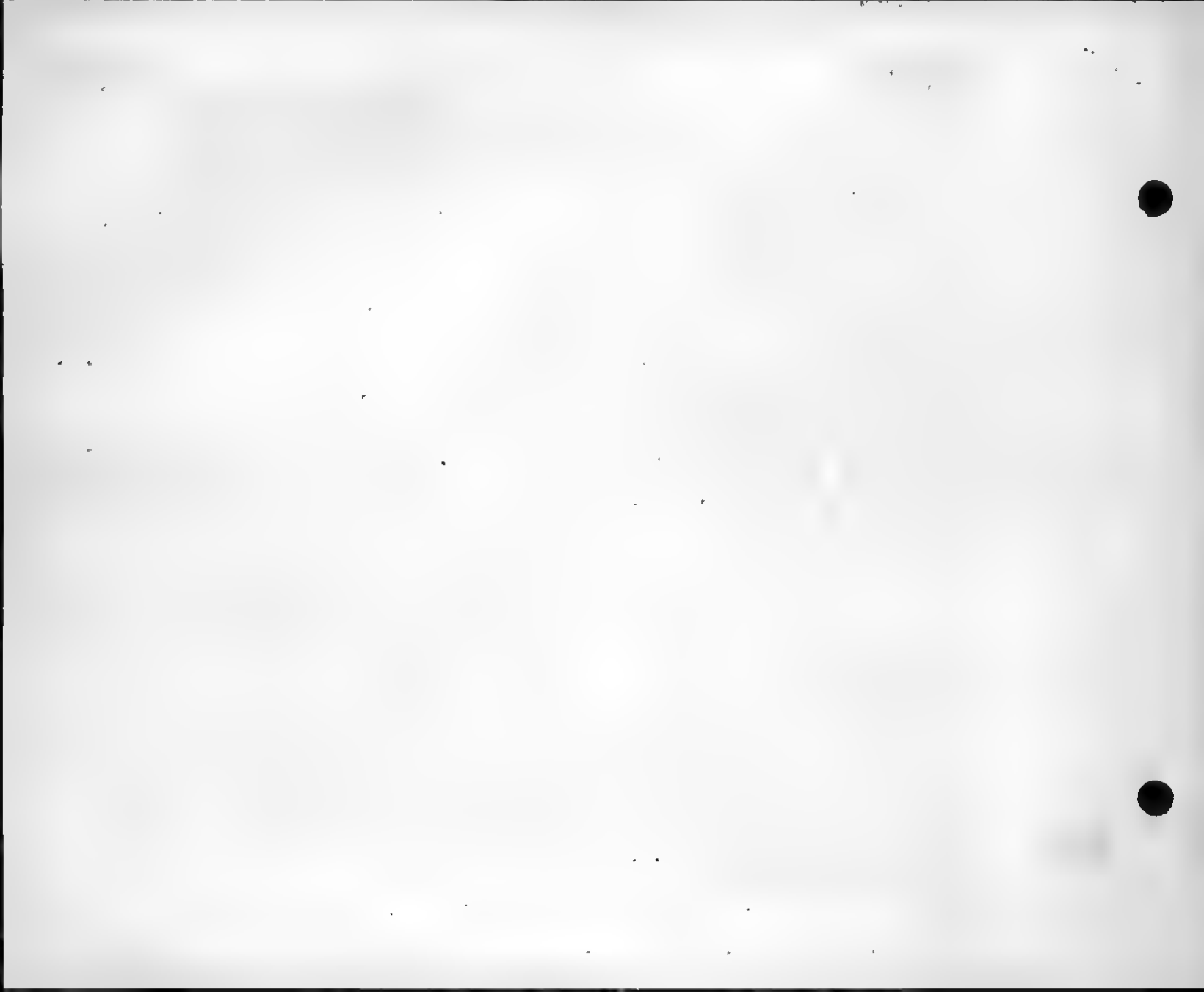
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #14 Film #G337 3/24/67 DC

CERTIFICATE OF DEATH

03959

03957

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>	
c. LENGTH OF STAY IN TB <u>11 days</u>		d. STREET ADDRESS <u>3315 W. COQUELIN TERR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>RICHARD H. SPENCER, SR.</u>		4. DATE OF DEATH <u>3</u> Month <u>7</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/93</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt-Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Mary O'Shea Magee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO <u>215-38-4353</u>	
17. INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u>		18. MOTHER'S MAIDEN NAME <u>Mary C. Spencer</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma in lungs with extension</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>into left atrium</u> DUE TO (c) <u>Adenocarcinoma of rectum</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/65</u> , 19 <u>65</u> , to <u>3/7/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/7/67</u> , 19 <u>67</u> , and that death occurred at <u>1:45</u> p.m. from causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs, M.D.</u>		22b. DATE SIGNED <u>3/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry Scruggs, M.D.</u>		22d. ADDRESS <u>5413 Cedar Lane, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

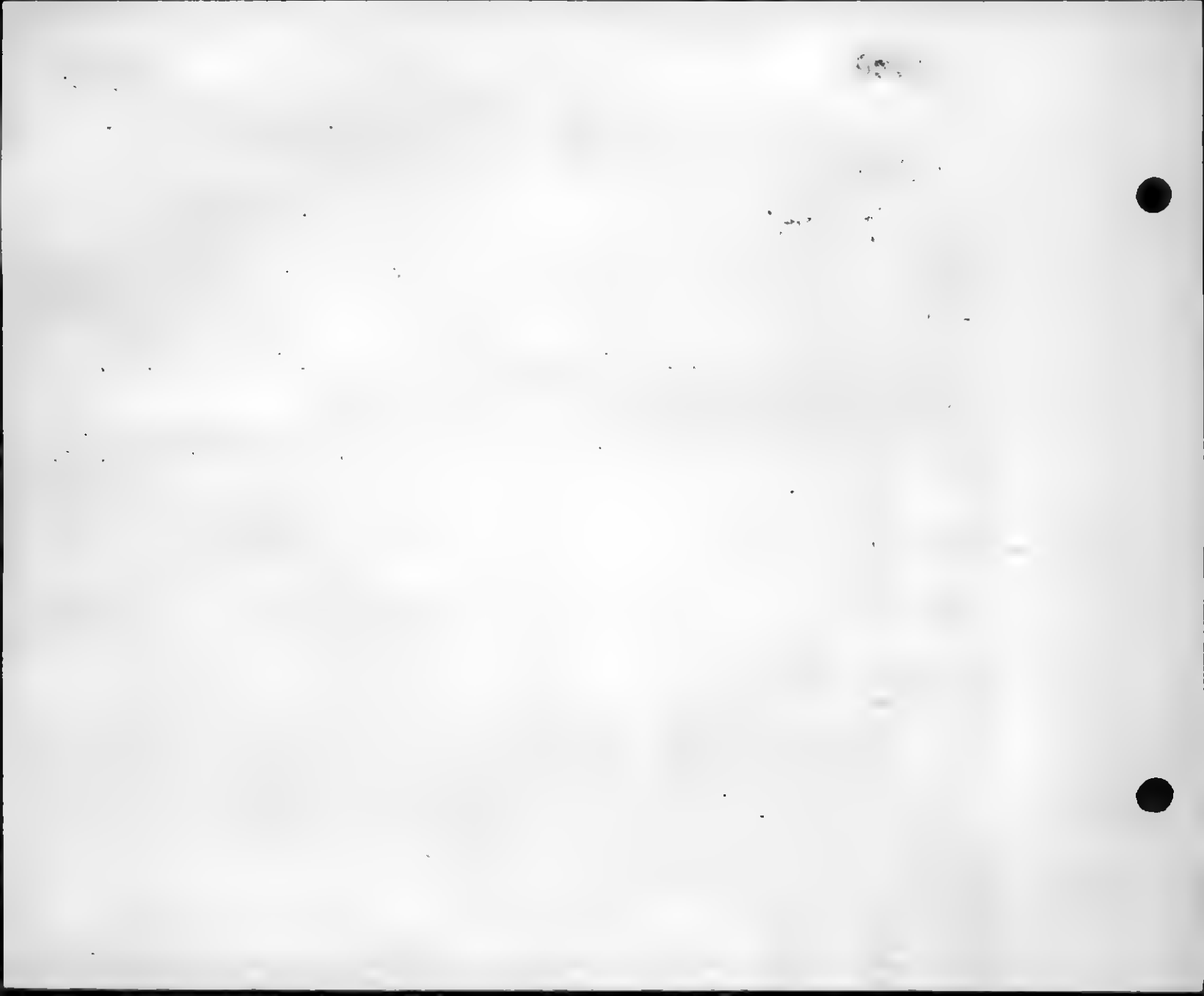
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23c & d per telephone from funeral home 3/10/67

03960

CERTIFICATE OF DEATH

03958

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>733 Sligo Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>Katherine</u> Last <u>Steinle</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22-1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 Year Months <u>6</u> Days <u>6</u> Hours <u>19</u> Min.	IF UNDER 24 HRS Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Principal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Public Schools</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Steinle</u>				14. MOTHER'S MAIDEN NAME <u>Clara Jowenall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>220-44-6360</u>		17. INFORMANT <u>Miss Elsie Michaelson</u> Address <u>733 Sligo Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> stating the underlying cause last (c) <u>Cachexia + malnutrition</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>year 1-</u> <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Sept</u> , 1967, to <u>3/6</u> , 1967, that (2) (we) last saw the deceased alive on <u>3/6</u> , 1967, and that death occurred at <u>2:10 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>James R. Coleman MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN MD.</u>				22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Maryland D.C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner C. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03961

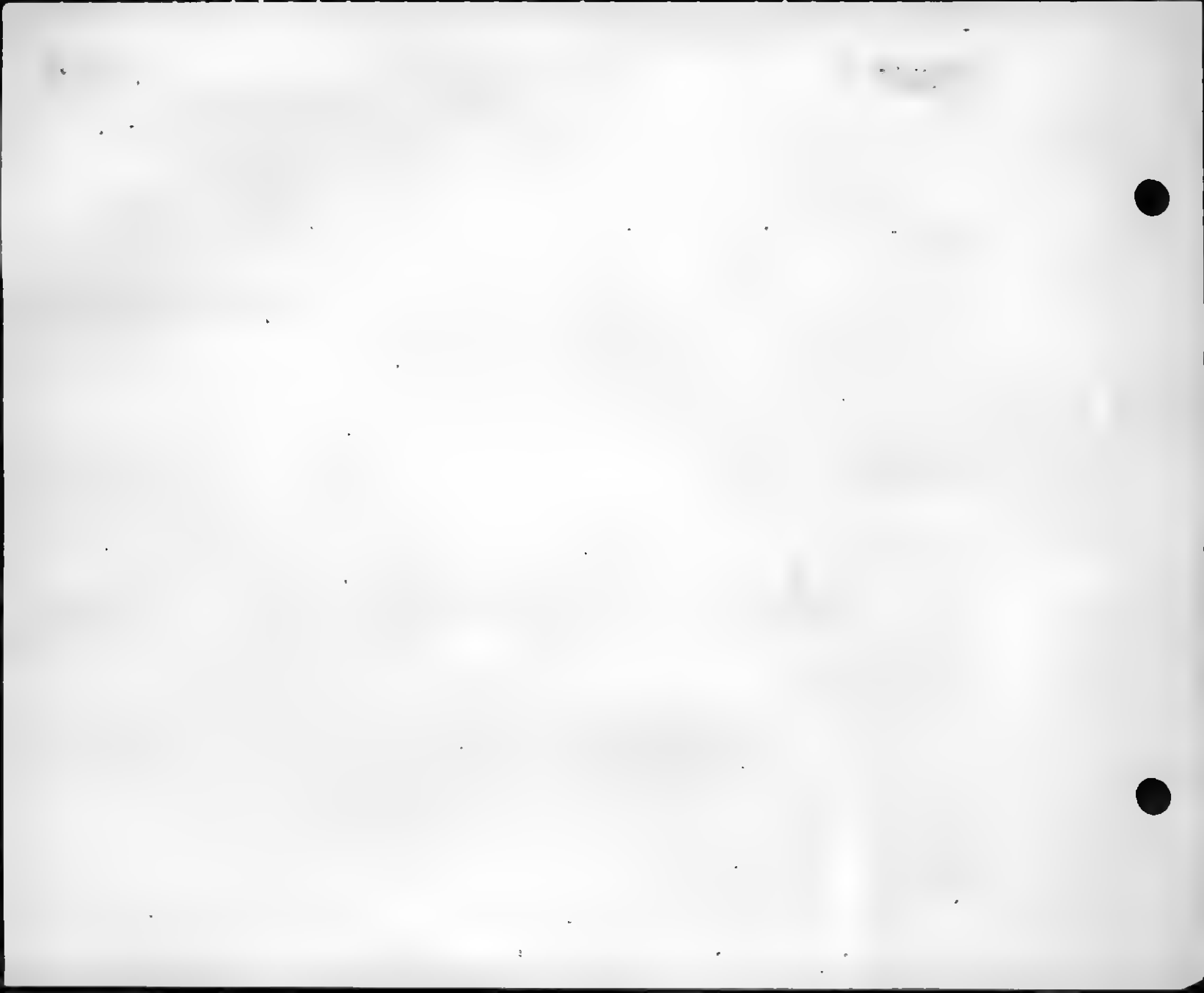
## CERTIFICATE OF DEATH

03960

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>48 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>Route #2, Box 12</u>		
3. NAME OF DECEASED (Type or print) First <u>Riley</u> Middle <u>(None)</u> Last <u>Stevenson</u>			4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>19 67</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 April 1929</u>		9. AGE (In years last birthday) <u>37</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Stevenson</u>			14. MOTHER'S MAIDEN NAME <u>Louise Curtis</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1951-1953</u>		16. SOCIAL SECURITY NO <u>215-26-4117</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas lung abscess</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hodgkin's Disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>9 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>6 February, 19 67</u> , to <u>26 March, 19 67</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>26 March 19 67</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Martin H. Cohen</u>		22b. DATE SIGNED <u>27 March 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Martin H. Cohen</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	
23d. LOCATION (City or Town) <u>Princess Anne, Md</u>		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR <u>William H. James Jr. Princess Anne, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

Cleared with Dr. Bearden Keap, D.M.E.

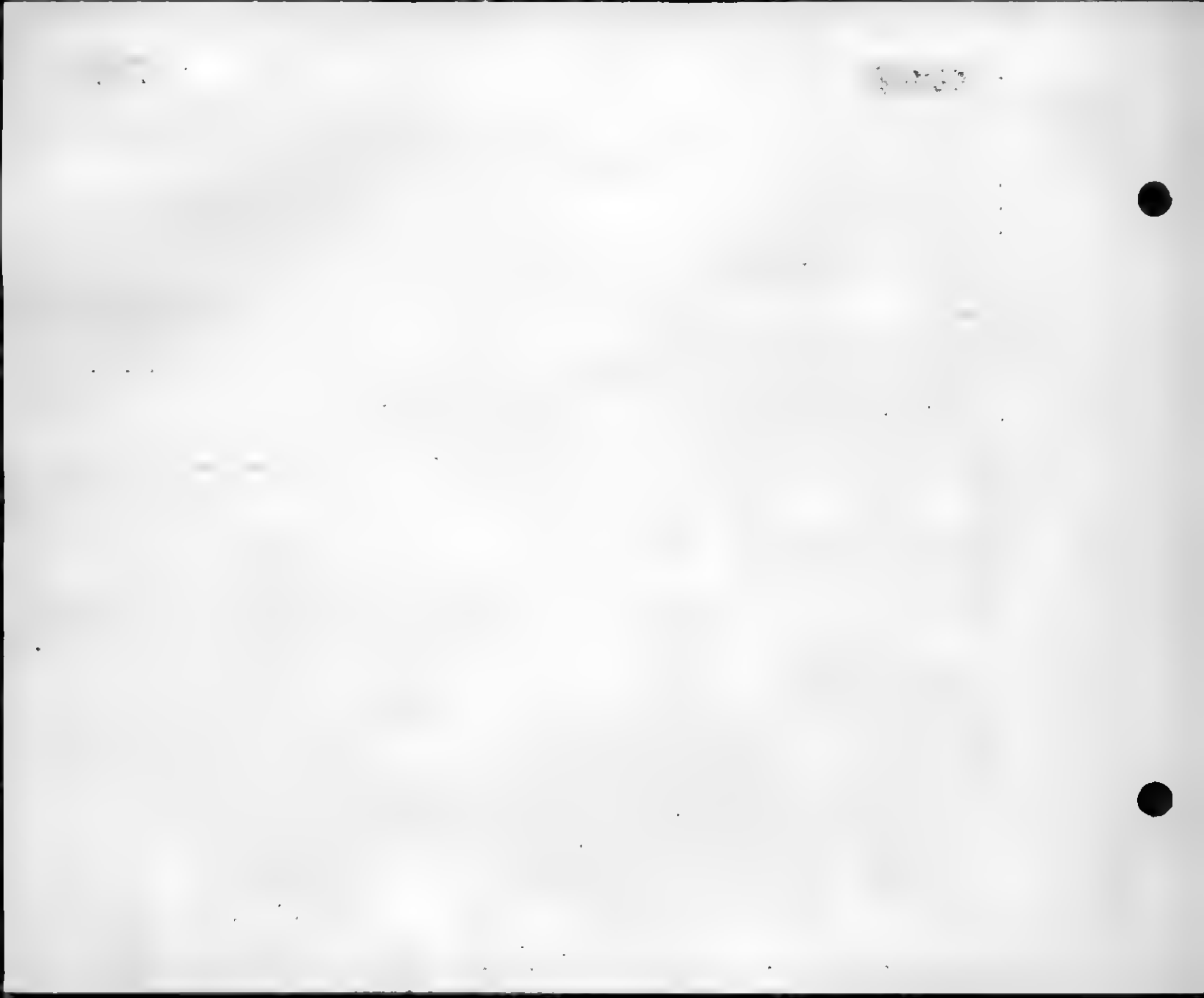
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03962

CERTIFICATE OF DEATH

03961

1 PLACE OF DEATH COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>3 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>815 Islington Street</i>		d. STREET ADDRESS <i>815 Islington Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Brook Oral Vernon Stewart</i>		4. DATE OF DEATH Month <i>Mar.</i>		Day <i>8</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. B. DATE OF BIRTH <i>April 15, 1904</i>		9. AGE (In years last birthday) <i>62</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plasterer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (County & State, or foreign country) <i>West Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Robert L. Stewart</i>		14. MOTHER'S MAIDEN NAME <i>Annie Beckett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Hannan P. Stewart</i>	
18. CAUSE OF DEATH (Enter on a cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastasized Carcinoma of Rectum</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinoma of Rectum</i> DUE TO (c) <i>2 years</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>1930</i> , to <i>2 Mar.</i> , 1967, that (1) (was) last saw the deceased alive on <i>28 Feb.</i> 1967, and that death occurred at <i>5:10 P.M.</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>M B Queen M.D.</i>		22b. DATE SIGNED <i>3/9/67</i>		22c. PHYSICIAN'S NAME (Type) <i>M B QUEEN</i>	
22d. ADDRESS <i>3421 University Blvd. W Silver Spring, Md.</i>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 11, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	
23d. LOCATION (City or Town) <i>Rockville, Maryland</i>		23e. REC'D BY REGISTRAR <i>Charles Judge</i>		23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
23g. FUNERAL DIRECTOR <i>Glen Capter</i>		23h. ADDRESS <i>8434 Georgia Avenue</i>		23i. DATE <i>MAR 13 1967</i>	
23j. NAME <i>Warner E. Pumphrey, Inc. Silver Spring, Md.</i>					



03963

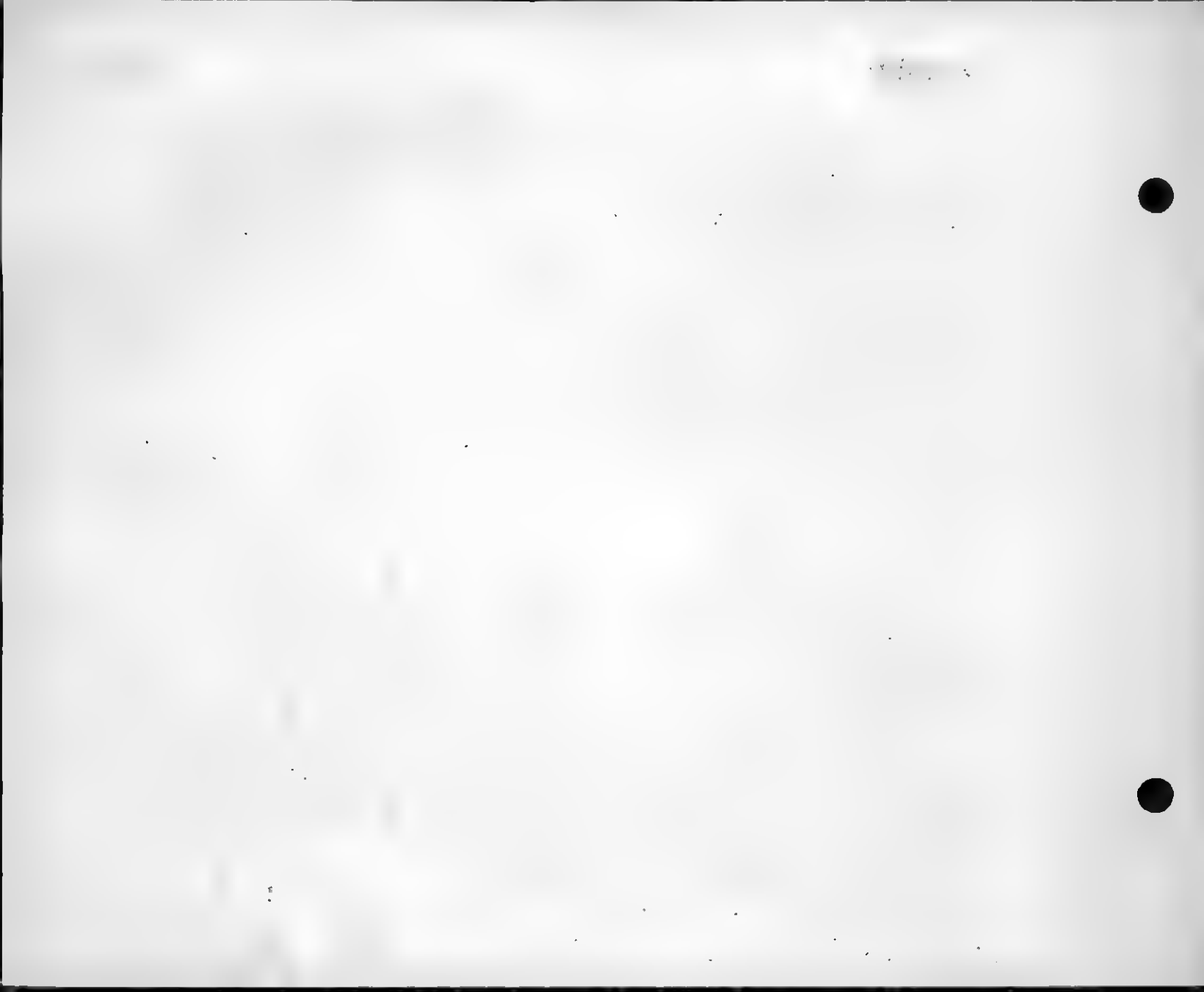
CERTIFICATE OF DEATH

03962

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>26 Days</u>				d. STREET ADDRESS <u>1580 East-West Highway</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elleta</u> Middle <u>Jewett</u> Last <u>Stuart</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 22-1887</u>	
9. AGE (In years last birthday) <u>79</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State or foreign country) <u>Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Forrester B. Burns</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wheeler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-30-1089</u>		17. INFORMANT <u>Erma Halliday</u> Address <u>1556 East West Highway Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1750 Congestive Heart Failure 24h</u> DUE TO (b) <u>Widespread carcinoma probably originating in ovary</u> DUE TO (c) <u>in ovary</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, malnutrition etc</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>March 2</u> , 19 <u>67</u> , that (II) (two) last saw the deceased alive on <u>2 March</u> 19 <u>67</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest F. Harmon</u> M.D.				22b. DATE SIGNED <u>2 March 67</u>		22c. PHYSICIAN'S NAME (Type) <u>Ernest F. Harmon</u>	
22d. ADDRESS <u>9301 Colasville Rd Silver Spring Md</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>March 6, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>				24. FUNERAL DIRECTOR <u>Glen Foster Warner E. Pumphrey, Inc. Silver Spring, Md</u>			
25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

03964

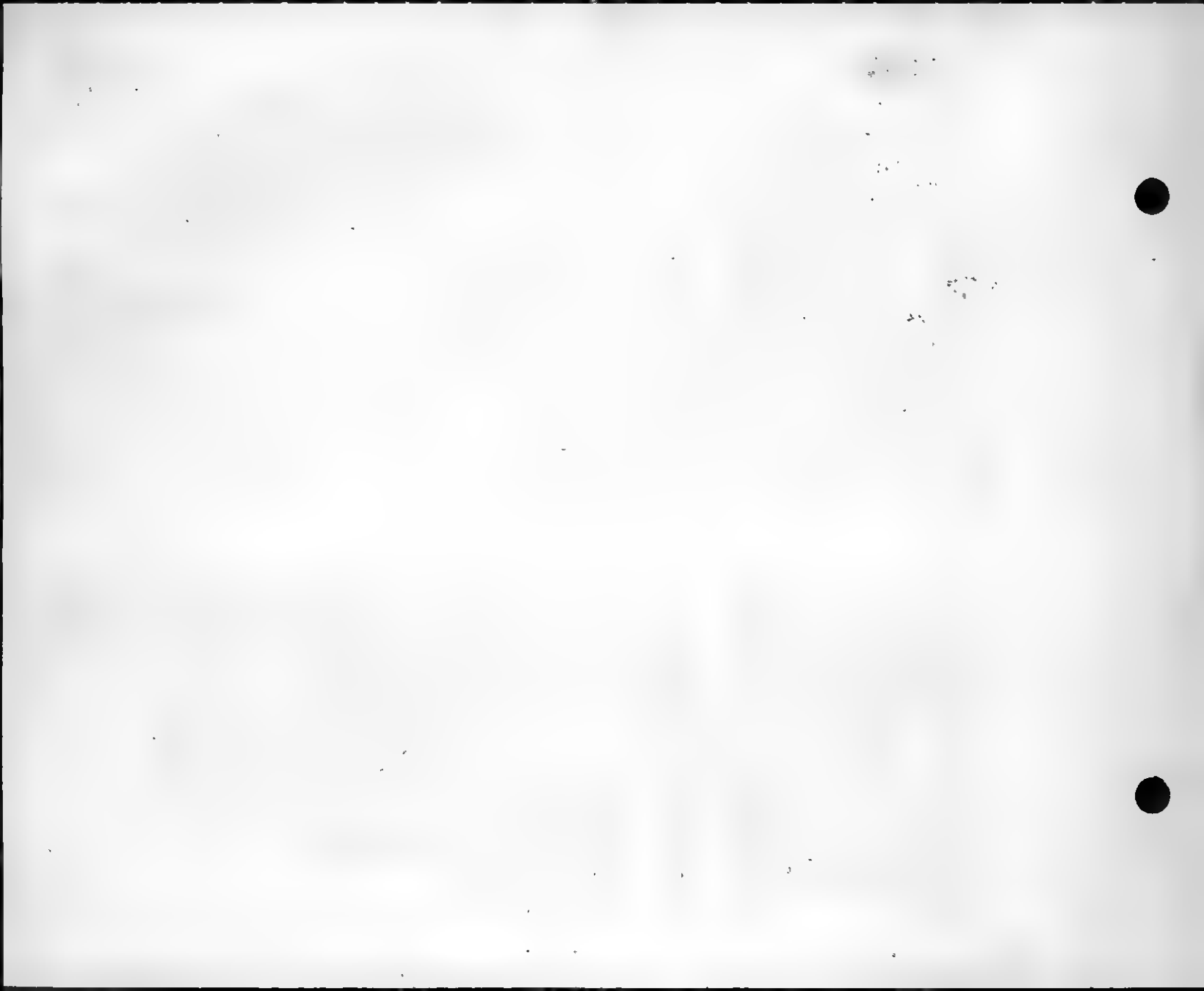
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03963

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>		d. STREET ADDRESS <b>6519 PARKWAY COURT</b>	
3. NAME OF DECEASED (Type or print) <b>EDWARD ELLSWORTH SULLIVAN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 31, 1915</b>
9. AGE (In years past birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>N.A.S.A.</b>	11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JOHN SULLIVAN</b>	
14. MOTHER'S MAIDEN NAME <b>TERESA MENZEL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>	
16. SOCIAL SECURITY NO <b>217-10-5932</b>		17. INFORMANT <b>MRS. KATHERINE SULLIVAN (WIFE)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>976x</b> IMMEDIATE CAUSE (a) <b>Gunshot wound in head with cerebral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>laceration and exsanguination</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased shot self in head</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:00 p.m. 3-13 1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Hyattsville Pr. Geo. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Heap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. HEAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>3/13/1967</b>		23. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 17, 1967</b>	
23c. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Pro Geo Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. RECD BY REGISTRAR <b>MAR 17 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

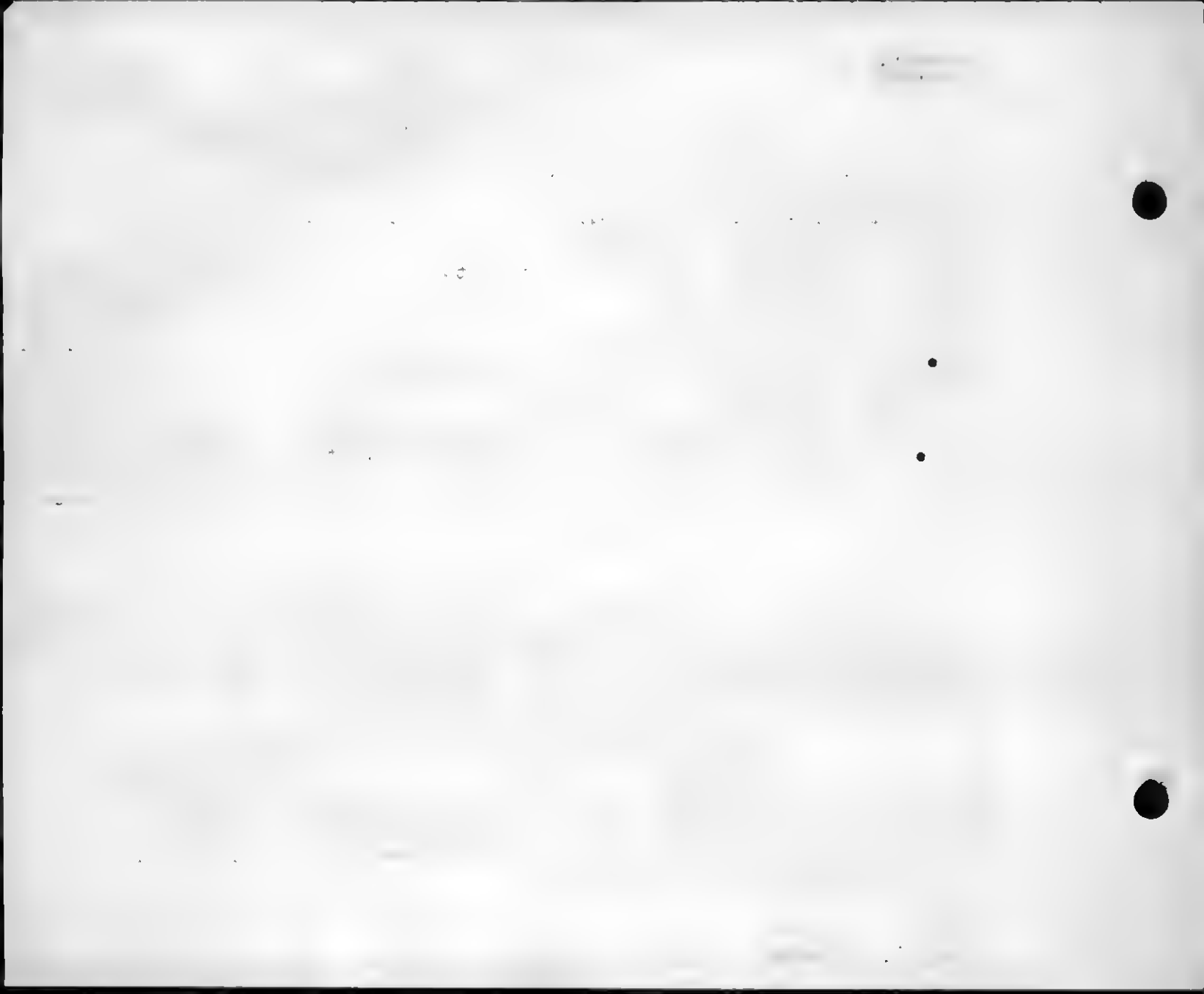
**03965**

**03964**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15.1			
c. LENGTH OF STAY IN lb <b>11 hours</b>				d. STREET ADDRESS <b>3721 Kayson Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bullard</b> Middle <b>Svenarton</b> Last <b>Svenarton</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1967</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-6-93</b>	
9. AGE (in years last birthday) <b>74 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Bullard</b>		14. MOTHER'S MAIDEN NAME <b>Ida Myer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no None</b>		16. SOCIAL SECURITY NO. <b>220-44-4359</b>		17. INFORMANT <b>Robert Svenarton</b> Address <b>3721 Kayson Street Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralytic ileus</b> DUE TO (b) <b>Colitis</b> DUE TO (c) <b>2 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Puerilis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>October, 1963</b> , to <b>15 March, 1967</b> , that (I) (we) last saw the deceased alive on <b>14 March 1967</b> , and that death occurred at <b>5:32 AM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Seruch T. Kimble</b>				22b. DATE SIGNED <b>3-15-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Seruch T. Kimble</b>	
22d. ADDRESS <b>921 Pershing Dr., S. S., Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas &amp; Son, Inc. 434 Georgia Avenue Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

03966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03965

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE <u>M.D.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in TB <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		d. STREET ADDRESS <u>733 SLIGO AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Wash. Ann. + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MAUDE Easton THATCHER</u>		4 DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>Fe</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-8-79</u>
9 AGE (In years, months, and days) <u>88</u> yrs		10 IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11 BIRTHPLACE (State or foreign country) <u>Illinois</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thomas Easton</u>		14 MOTHER'S MAIDEN NAME <u>Cornelia Hoff</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>Yes</u>	
17 INFORMANT <u>Tom B. Thatcher</u> Address <u>7207 Chestnut St</u>		<u>XXXXXX Chevy Chase, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to aspiration of gastric contents</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B) <u>Deceased vomited and aspirated gastric contents</u>	
20c TIME OF INJURY Month Day, Year <u>1:00</u> <u>3-24</u> <u>1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Hospital</u>		20f (City or town) (County) (State) <u>Takoma Park</u> <u>Montg</u> <u>Md</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>3/24/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>		Address (Street, City, Town, County) _____	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Mar 27, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a REC'D BY REGISTRAR <u>29 1967</u>	
Address <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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YR A15 (4)  
20 M 1/66

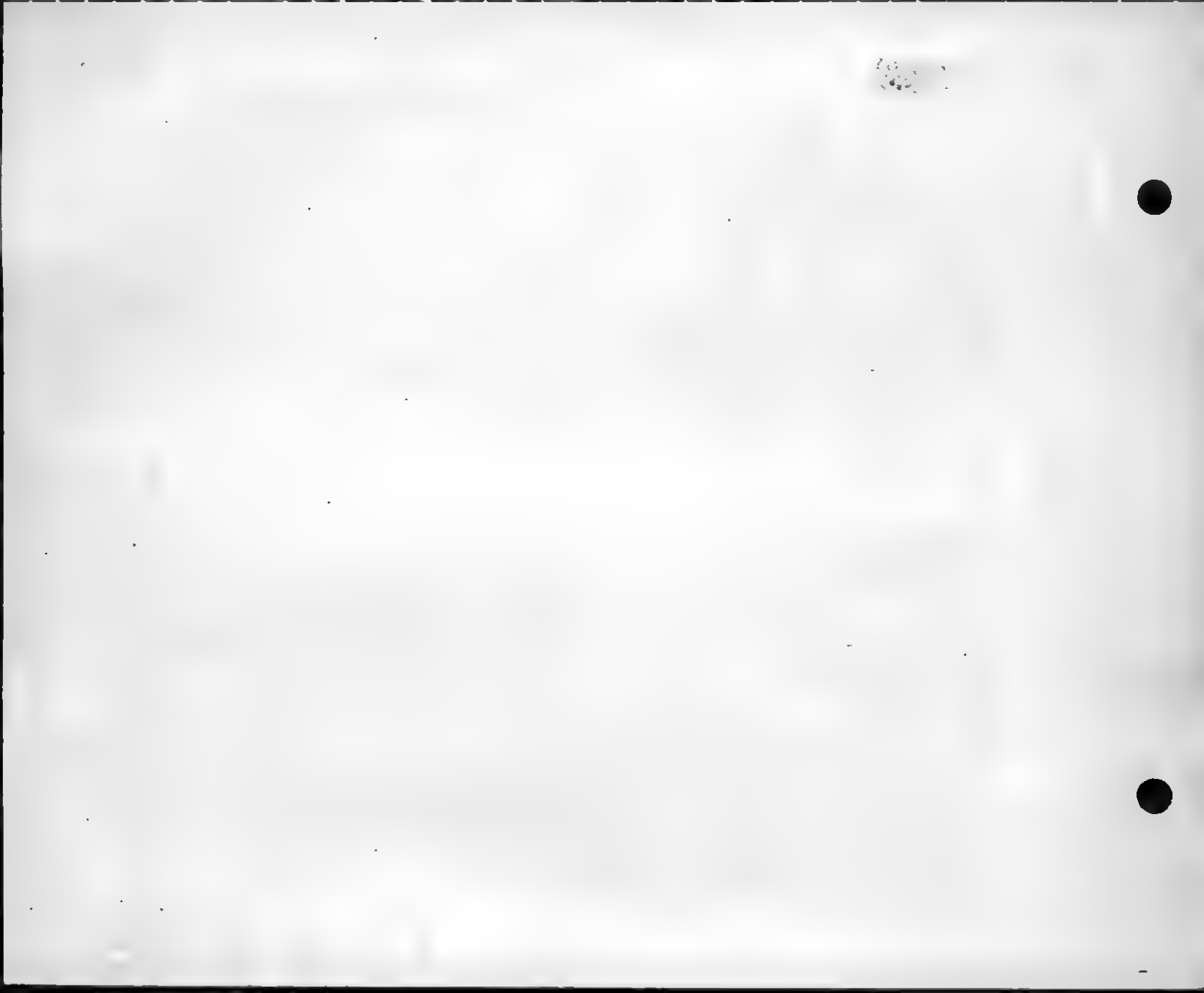
MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03967

CERTIFICATE OF DEATH

03966

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11111</u>		d. STREET ADDRESS <u>11111</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Thomas</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18 1885</u>
9. AGE (In years lost birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Bond</u>		14. MOTHER'S MAIDEN NAME <u>Hmirah Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>1-111-1111</u>	
17. INFORMANT <u>Tamie Dorsey (nephew)</u>		Address <u>11111</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion, acute</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>Hypertensive heart disease</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis - Large ventricular aneurysm</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>phlebotomy</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Spencerville, Md.</u>
21. I certify that (1) (this hospital) attended the deceased from <u>Sept 14, 1964</u> to <u>Mar 15, 1967</u> , that (1) (we) last saw the deceased alive on <u>Feb 3, 1967</u> , and that death occurred at <u>10:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John R. Spencer</u>		22b. DATE SIGNED <u>3-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>		22d. ADDRESS <u>BURTONSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spencerville Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Spencerville, Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Spencer</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
ADDRESS <u>11111</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

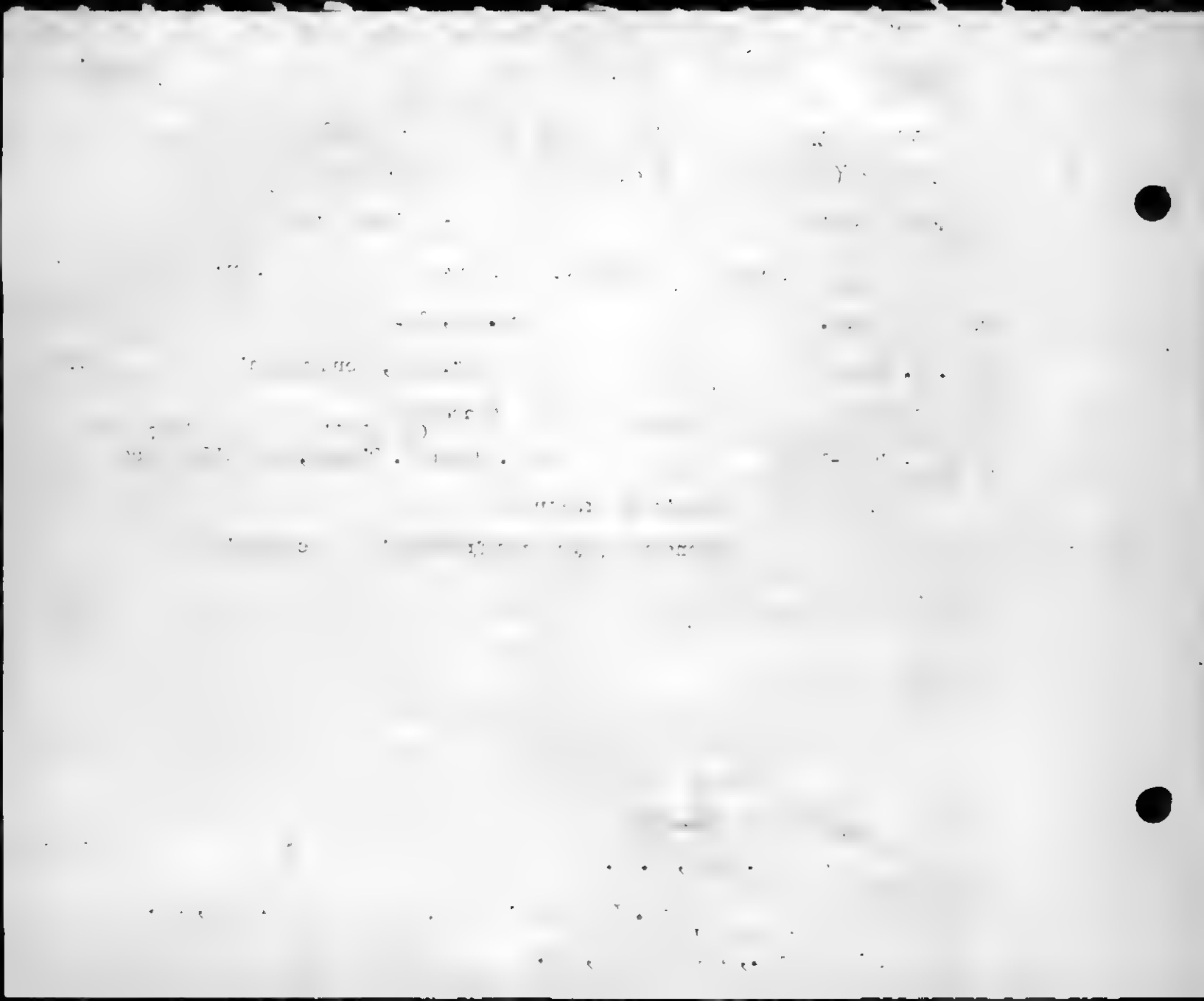
03968

03967

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Greenbelt</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b> d. STREET ADDRESS <b>69-K Ridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Shoemaker Thomas</b>		4. DATE OF DEATH Month Day Year <b>March 16 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1915</b>
9. AGE (In years last birthday) <b>51 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Chester, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Grace Hock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes 1934-1956</b>		18. SOCIAL SECURITY NO.	
17. INFORMANT <b>Greenbelt</b> <b>Mrs. Helen G. Thomas, 69K Ridge Road</b>		Address <b>Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardia arrest-sudden</b> DUE TO (b) <b>Extensive lympho carcinomatosis of peritonium</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>John G. Ball, M. D.</b>		22. DATE SIGNED <b>17 March 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>March 21, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> <b>4739 Baltimore Ave., Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 20 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03969

CERTIFICATE OF DEATH

03968

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> D.C. b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>6621 Piney Branch Road N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rose E. Tabb</u>			<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>8</u> Year <u>1967</u>				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>Can</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12/4/1899</u>	<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Samper</u>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore M. D.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				
<b>13. FATHER'S NAME</b> <u>Morris Tabb</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Rebecca Brooks</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO</b> <u>UNKNOWN</u>		<b>17. INFORMANT</b> <u>P. R. Tabb</u> Address <u>13,000 GA. AVE. S.E. WASH. D.C.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Leukemia chr. Myelogenous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension Heart Dis.</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 yrs.</u> <u>13 mrs.</u> <u>5 yrs.</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to March 8, 1967, that (I) (we) last saw the deceased alive on March 8, 1967, and that death occurred at 3:00 P.M. from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>P. R. Tabb</u>		<b>22b. DATE SIGNED</b> <u>3/8/67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>S. E. TABB, M.D.</u>			
<b>22d. ADDRESS</b> <u>13,000 GA. AVE. S.E. WASH. D.C.</u>		<b>22e. DATE</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>3/10/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>BNAI ISRAEL CEM.</u>			
<b>23d. LOCATION (City or Town) (County) (State)</b> <u>OXON HILL, MD.</u>		<b>23e. FUNERAL DIRECTOR</b> <u>Shelley Funeral Home</u>					
<b>23f. ADDRESS</b> <u>4217-9th Ave</u>		<b>23g. REC'D BY REGISTRAR</b> <u>MAR 13 1967</u>		<b>23h. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a, b, c & d Form #1305 3/23/67 pg

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03970

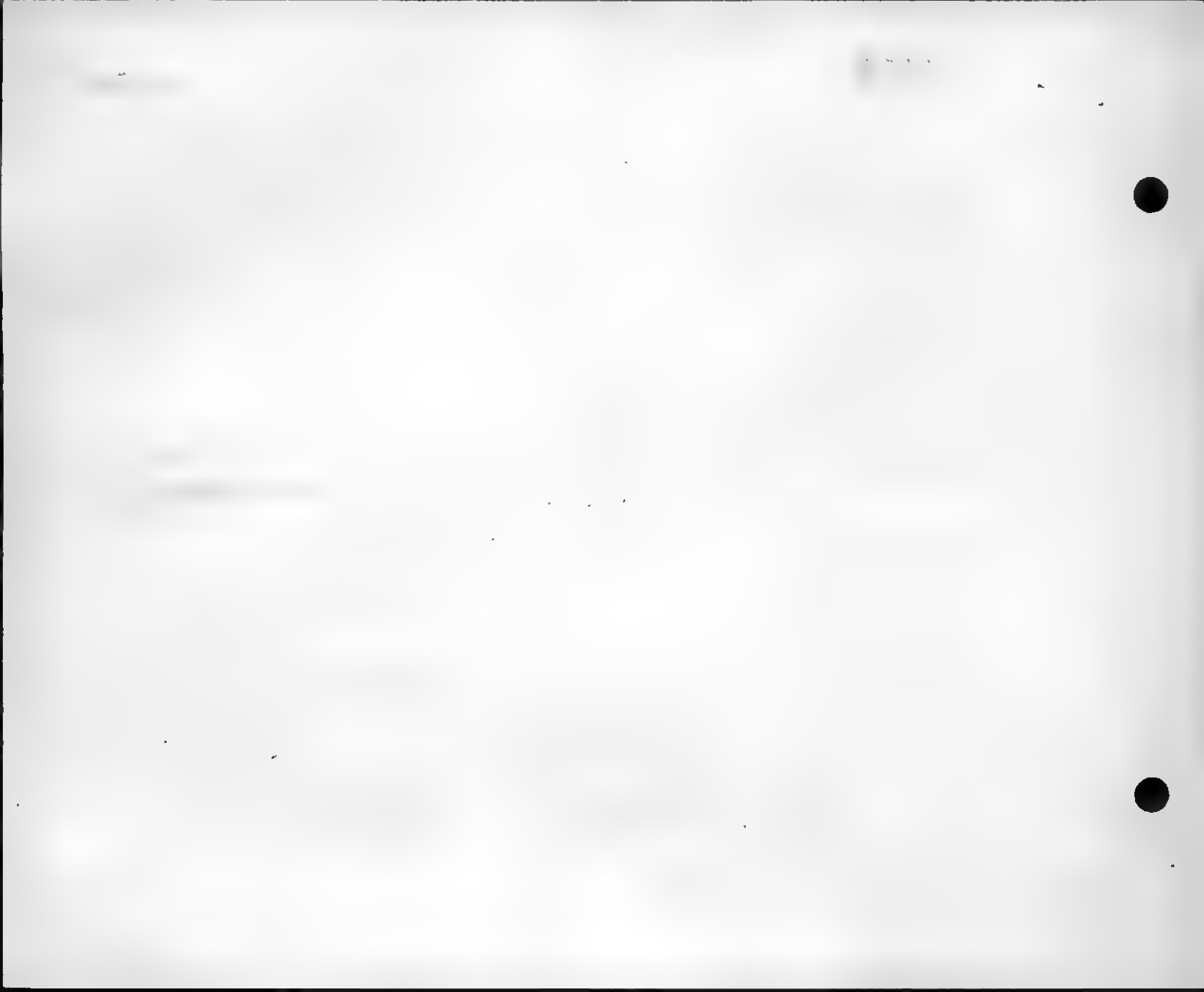
03969

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

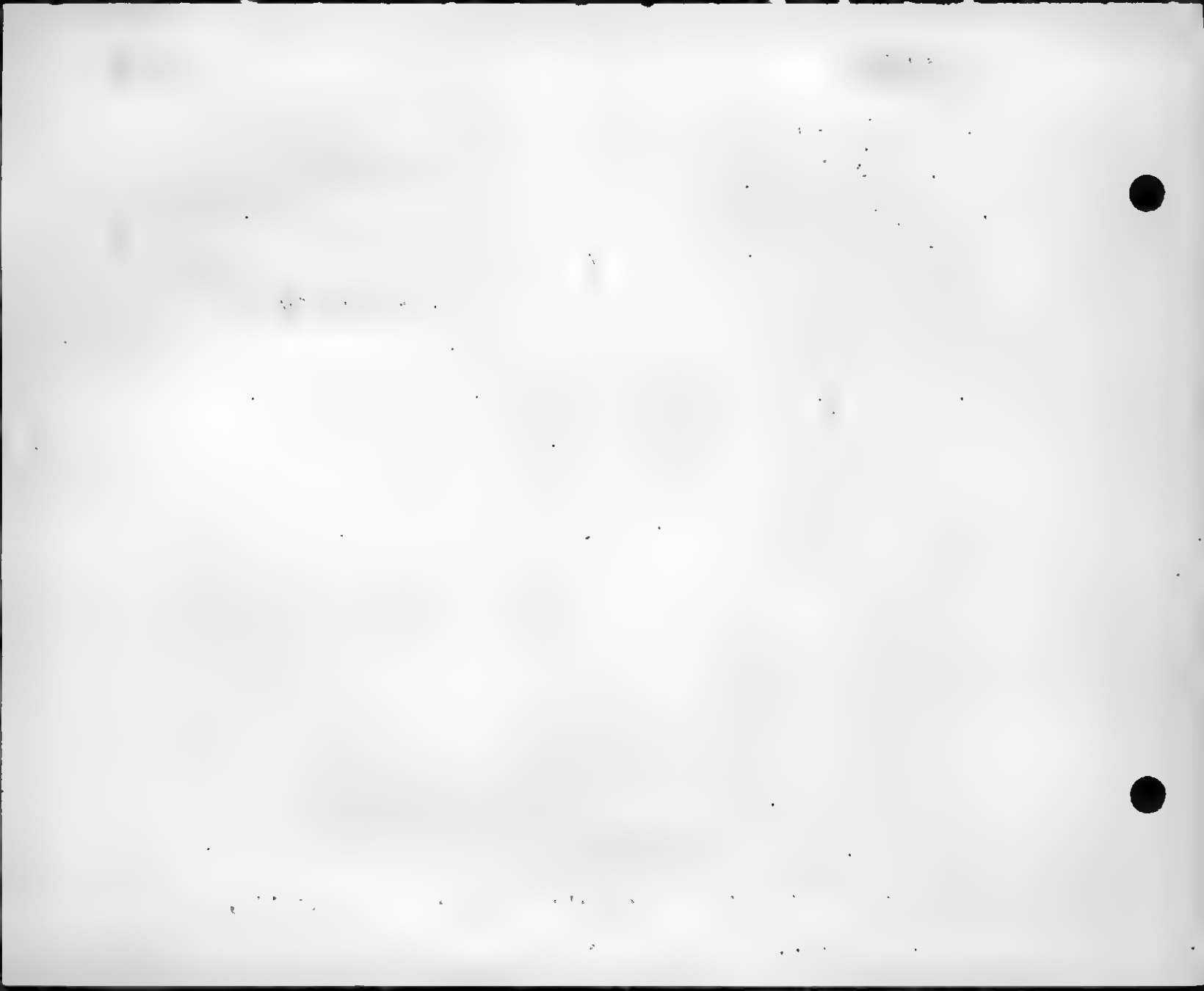
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>D.C.</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>4 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d STREET ADDRESS <u>2430 Ontario Rd., N.W.</u>	
3 NAME OF DECEASED (Type or print) First <u>Emmett</u> Middle <u>(none)</u> Last <u>Trent</u>		4 DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-11-80</u>
9a AGE (In years last birthday) <u>86</u> yrs		9b IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Wales Trent</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Washington Sanitarium &amp; Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Pneumonia &amp; Confluent Ptysing</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		22. DATE SIGNED <u>3/9/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>3-12-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d LOCATION (City or town) (County) (State) <u>FARMVILLE, VIRGINIA</u>
24 FUNERAL DIRECTOR <u>W. ERNEST JARVIS CO.</u>		25a REC'D BY REGISTRAR <u>13 1967</u>	
ADDRESS <u>1432 YOU STREET, N.W.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
039771						039770					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>MONTGOMERY</b>						a. STATE <b>MD.</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>						b. COUNTY <b>MD.</b>					
c. LENGTH OF STAY IN 1b <b>7 DAYS</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FAIRLAND NURSING HOME</b>						d. STREET ADDRESS <b>3652 MALDEN AVE</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>LENA FRANCES EL TRIPLITT</b>						4. DATE OF DEATH Month <b>3</b> - Day <b>14</b> Year <b>1967</b>					
5. SEX <b>F</b>						6. COLOR OR RACE <b>W</b>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>1899</b>					
9. AGE (in years last birthday) <b>67 yrs.</b>						10. IF UNDER 1 YEAR Months <b>3</b> Days <b>14</b> Hours <b>19</b> Min. <b>67</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>					
11. BIRTHPLACE (Country & State, or foreign country) <b>MARYLAND</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>JOHN BASSLER</b>						14. MOTHER'S MAIDEN NAME <b>LENA BROWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <b>215-10-5930-D</b>					
17. INFIRMANT <b>GLORIA L. MCGOWAN-LAUREL, MD.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Thyroid with metastases</b> 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>to metastases in bones</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1967</b> to <b>March 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 12, 1967</b> and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Boris Robkin</b>											
22b. DATE SIGNED <b>3/14/67</b>											
22c. PHYSICIAN'S NAME (Type) <b>BORIS ROBKN</b>											
22d. ADDRESS <b>1019 Union Blvd EAT</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>											
23b. DATE THEREOF <b>3/18/67</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>Sater's Cemetery</b>											
23d. LOCATION (City, town or county) (State) <b>Balto Co, Md</b>											
24. FUNERAL DIRECTOR <b>Austin E. Donovan</b>											
25a. REC'D BY REGISTRAR <b>20 1967</b>											
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											





FOR STATE  
 HEALTH DEPT

03972

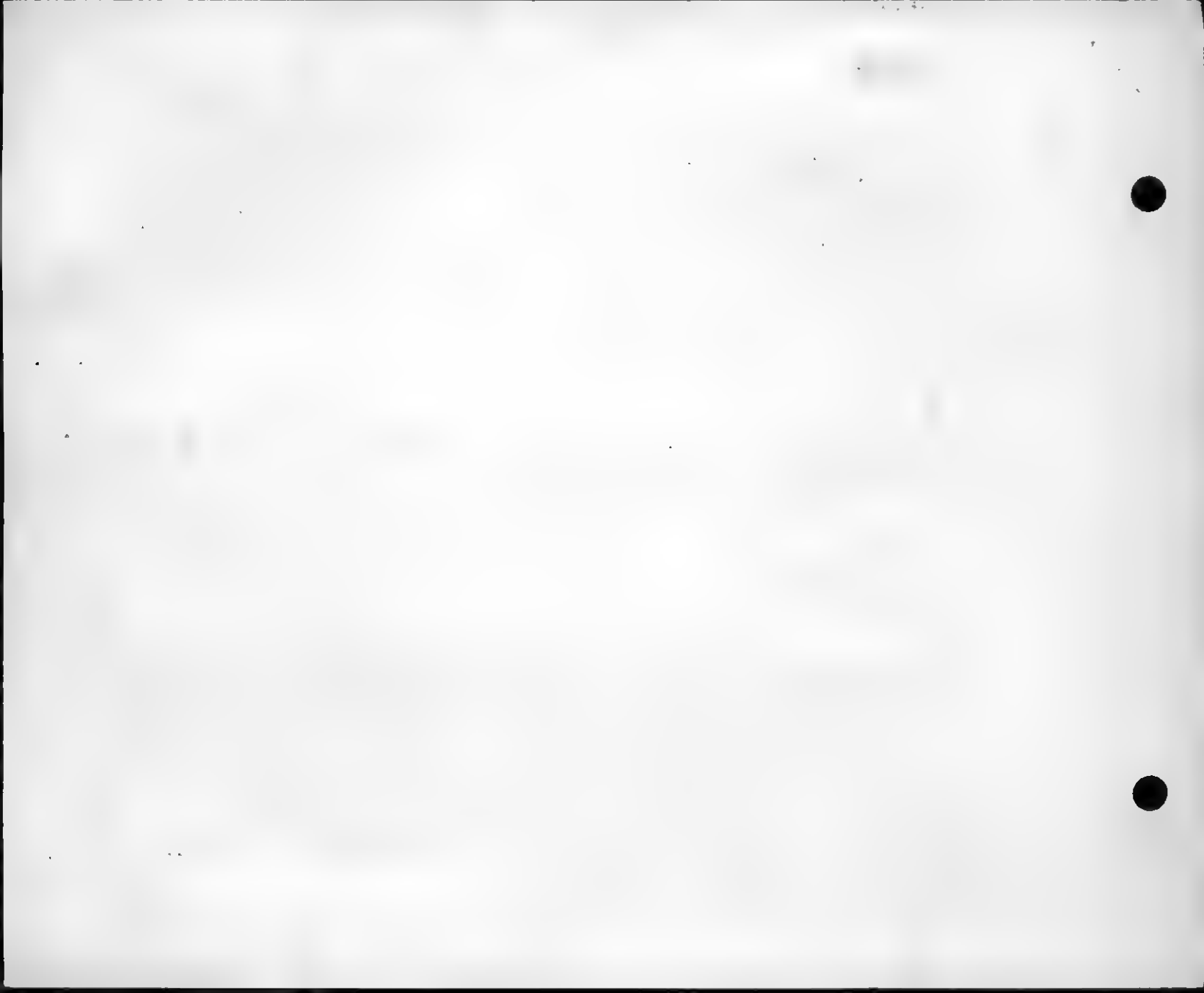
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03971

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased resided, if not in residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Wheaton)</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Howard Hanson Motel</u>		d. STREET ADDRESS <u>11112 Edmonston DR</u>	
3 NAME OF DECEASED (Type or print) <u>JOSEPH B Udovich</u>		4 DATE OF DEATH <u>MARCH 24 1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-21-25</u>
9 AGE (in years last birthday) <u>41</u> yrs		10 F UNDER 14 HRS <u>167</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Principal Board of Education</u>		10b KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11 BIRTHPLACE (State or foreign country) <u>U. S.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>Joseph Udovich</u>		14 MOTHER'S MAIDEN NAME <u>Mary Gaspertitch</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW II</u>		16 SOCIAL SECURITY NO <u>109-20-8161</u>	
17 INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u>		18 NAME OF INFORMANT <u>Catherine Udovich</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Acute coronary insufficiency</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____			19 WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home farm factory street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reaph</u> M.D.		22. DATE SIGNED <u>3/24/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAPH, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County) _____	
23a BURIAL, CREMATION, REMOVALS (Specify) <u>Burial</u>	23b DATE THEREOF <u>3/28/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>American Legion Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Princess Anne, Maryland</u>
24 FUNERAL DIRECTOR <u>Robert G. Humphrey</u> Address <u>Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>MAR 30 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

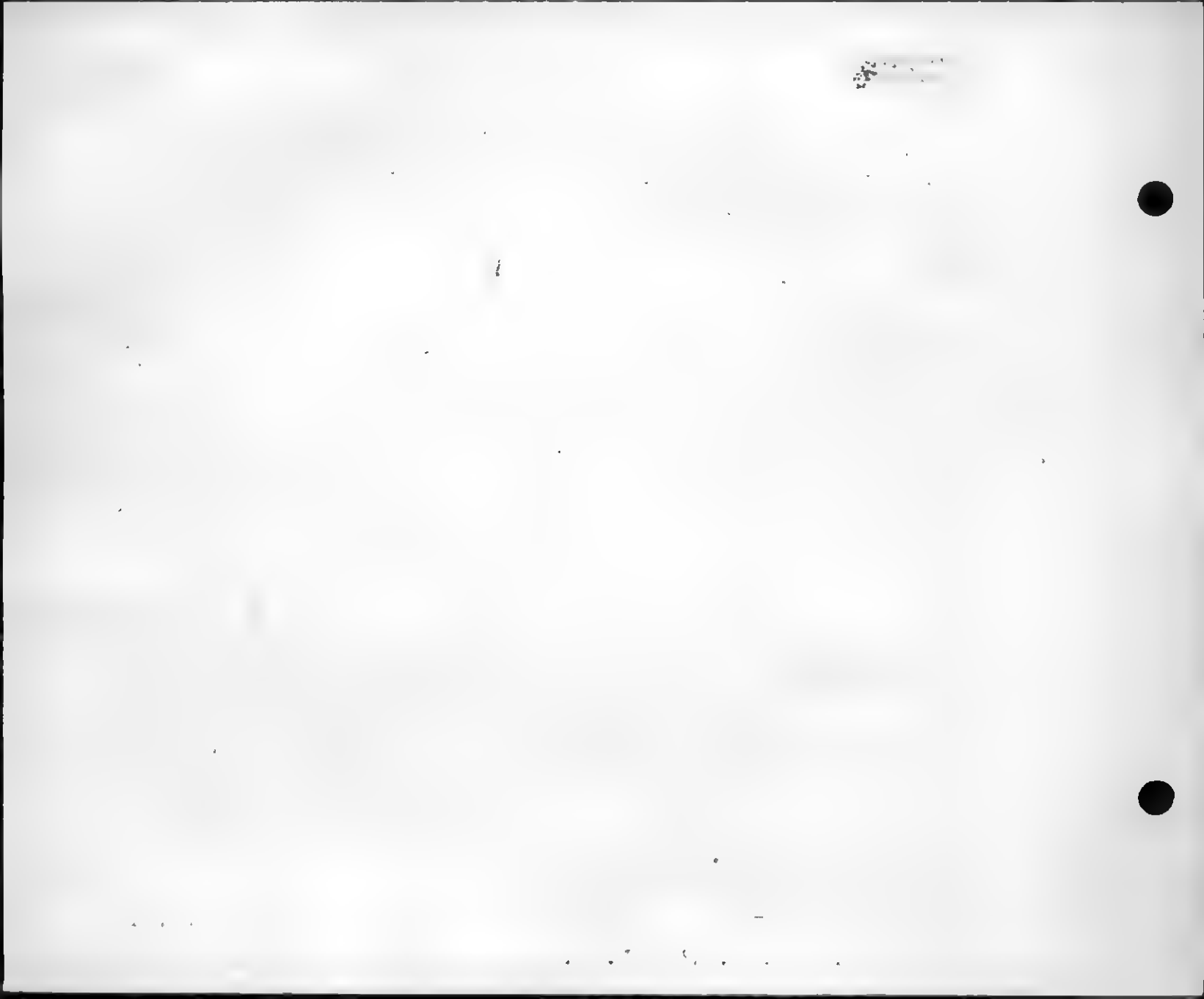
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03973

CERTIFICATE OF DEATH

03972

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 hrs 4 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sheridan Hospital</u>		d. STREET ADDRESS <u>405 Baithers St</u>	
3. NAME OF DECEASED (Type or print) <u>Angelina</u> First Middle Last		4. DATE OF DEATH <u>MARCH 28 1967</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-99</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Kaufman</u>		14. MOTHER'S MAIDEN NAME <u>Rose (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-40-7396</u>	
17. INFORMANT <u>Elfrieda Mitsilius (Daughter)</u>		Address <u>See item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRHAGE</u> DUE TO (b) <u>ARTERIO SCLEROTIC CEREBRAL-VASCULAR DISEASE</u> DUE TO (c) <u>5 YRS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>26 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF THYROID</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 15 1958</u> , to <u>MARCH 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 27 1967</u> , and that death occurred at <u>3:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>MARCH 28, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-31-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisconsin Ave. N.W. Wash. DC.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 31 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

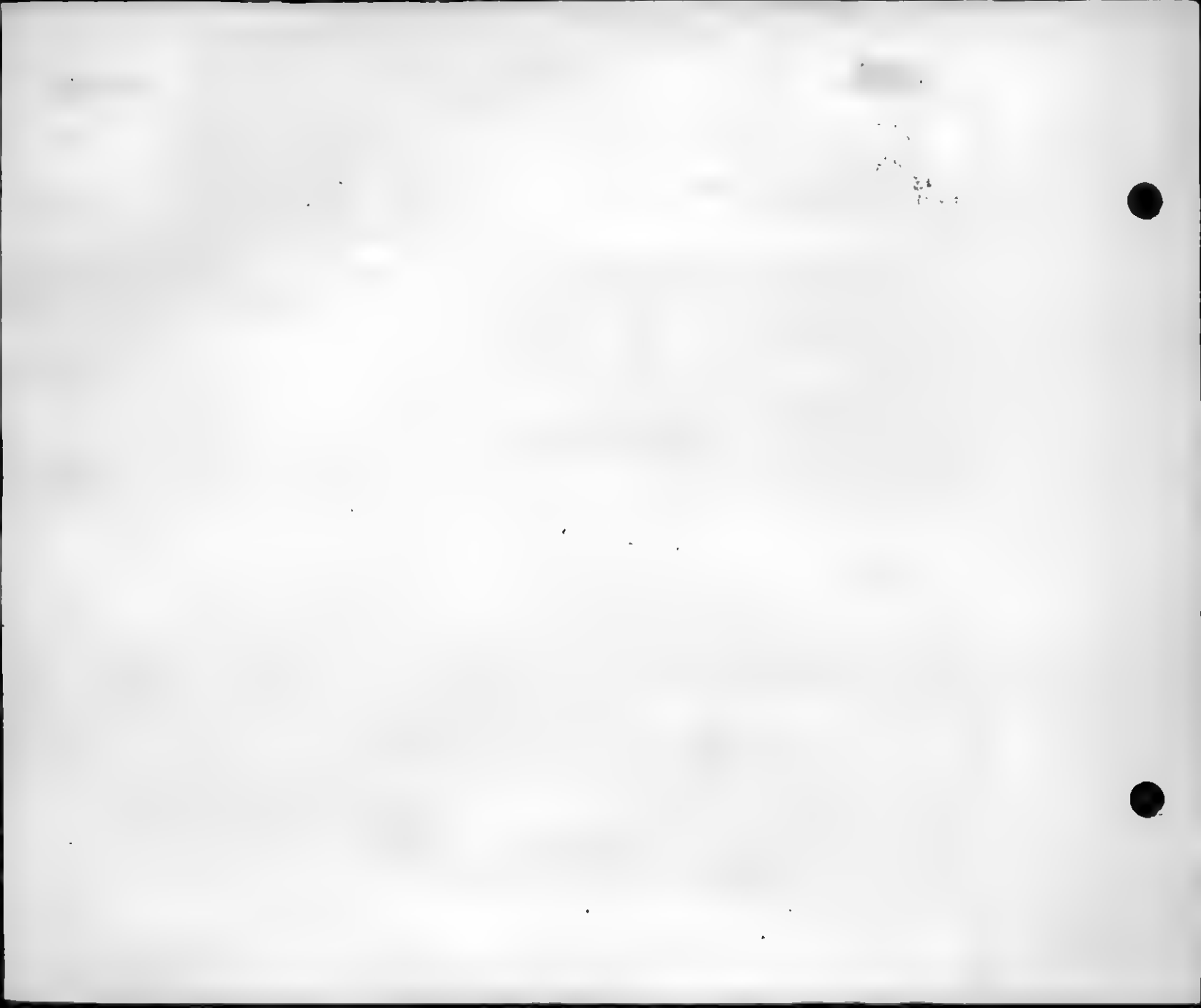
CERTIFICATE OF DEATH

03974

03973

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN IT <u>4 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium</u>		e. STREET ADDRESS <u>6223 Shadyside Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Stephen DAVID Vaughan</u>		4. DATE OF DEATH <u>MARCH 22 1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 18, 1885</u>
9 AGE (In years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTAINER</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13 FATHER'S NAME <u>Stephen Vaughan</u>	
14 MOTHER'S MAIDEN NAME <u>Annie Davis</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16 SOCIAL SECURITY NO <u>578-32-5461</u>		17. INFORMANT <u>Mrs. Edw. Schmidt</u> Address <u>Capital Hts., Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO <u>Stasis, vascular, and inactivity</u> DUE TO <u>Generalized and cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>many months</u> <u>2 many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 20, 1967</u> , to <u>March 22, 1967</u> , that (I) (we) lost saw the deceased alive on <u>3/14</u> 1967, and that death occurred at <u>8:00</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>George H. Mitchell</u> M.D.		22b. DATE SIGNED <u>March 22 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. George H. Mitchell</u>		22d. ADDRESS <u>11125 Rockville Pike - Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE TIME OF <u>3/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATIONAL CEMETERY</u>	23d. LOCATION (City or town) (County) (State) <u>PRINCE GEORGES, MARYLAND</u>
24 FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u> ADDRESS <u>4308 SUITLAND ROAD, SUITLAND, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>R 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

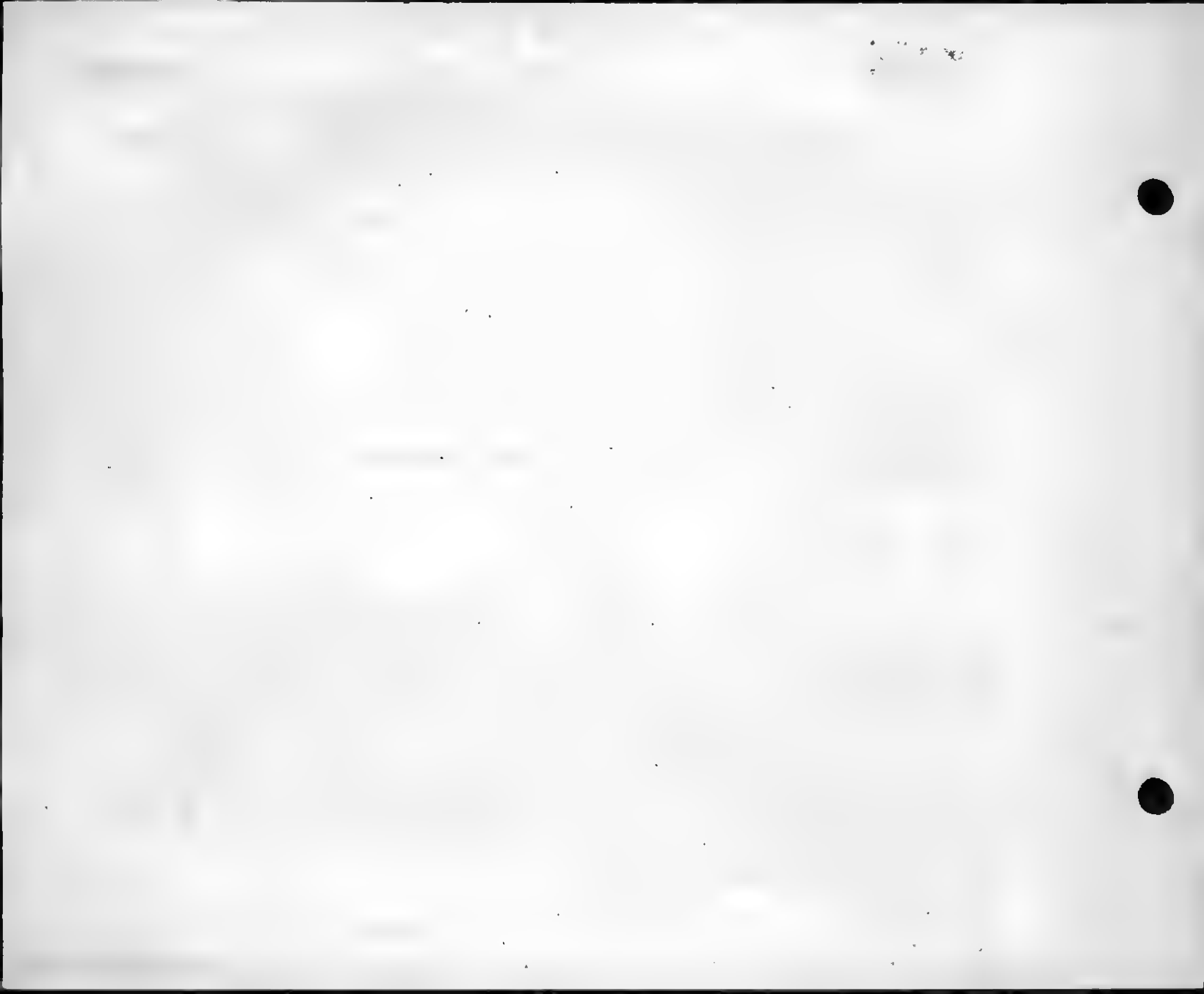
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03975

CERTIFICATE OF DEATH

03974

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>5 1/2 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clevie</u> Middle <u>Taylor</u> Last <u>Wadford</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov 20 1886</u>	9. AGE (In years last birthday) <u>80</u> yrs.	10. IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>6</u> Min <u>7</u>		11. IF UNDER 24 HRS. Months <u>13</u> Days <u>19</u> Hours <u>6</u> Min <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>	
12. CIT ZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Frances Kilgore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO <u>215-547424</u>		17. INFORMANT <u>Katherine Lang</u>	
				Address <u>8201 16th Street Silver Spring, Md</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>471X Bronchopneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>66</u> to <u>Mar 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 12</u> , 19 <u>67</u> , and that death occurred at <u>12:20</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Wadler</u> M.D.				22b. DATE SIGNED <u>March 13, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>	
22d. ADDRESS <u>8218 Wise Av. Bethesda</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>				23b. DATE THEREOF <u>March 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Largo Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Largo, Florida</u>				23e. DATE OF REGISTRATION <u>MAR 16 1967</u>		23f. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>	
23g. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. Silver Spring, Md</u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03976

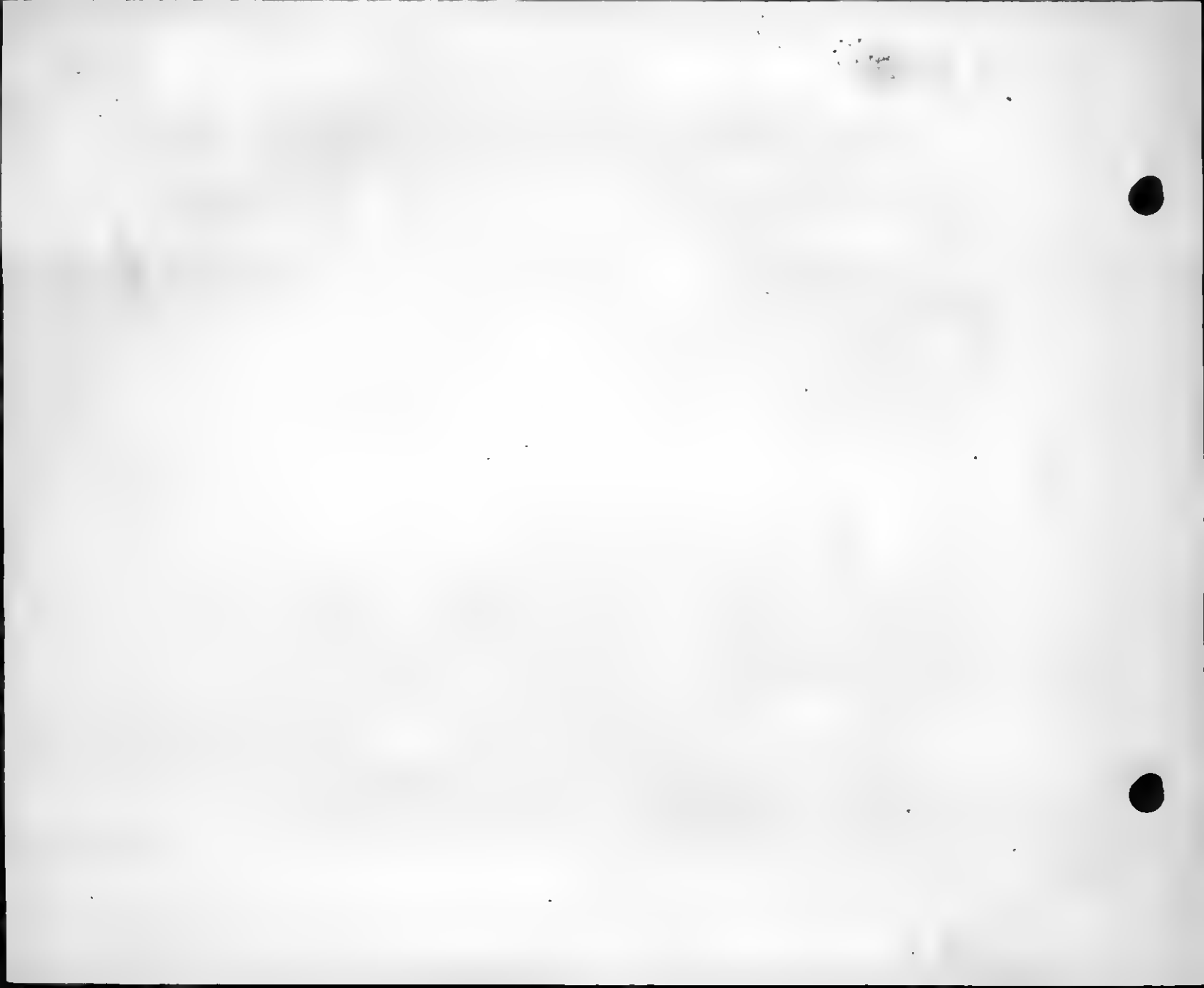
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03975

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u> c. LENGTH OF STAY IN ID <u>Washington</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington</u>				2. USUAL RESIDENCE (Where deceased lived; If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u> d. STREET ADDRESS <u>911 Sago Creek Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>August</u> First Middle Last		4. DATE OF DEATH <u>March 7</u> Month Day Year		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/21/1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Cleveland Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reinhold A. Wrechter</u>				14. MOTHER'S MAIDEN NAME <u>Emilie Herbst</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>21-1-1212</u>				17. INFORMANT <u>Mary E. Wrechter</u> Address <u>(Same as #2 above)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, Congestive heart failure</u>																INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 22</u> , 19 <u>67</u> , to <u>37</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-7</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> PM, from the causes and on the date stated above.																					
22a. SIGNATURE <u>Burne M. Bandler</u>																22b. DATE SIGNED <u>3/7/1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>B. G. BENDLER</u>																22d. ADDRESS <u>10820 Georgia Ave, Wheaton, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>3/11/1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Wheaton Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Wheaton, Md</u>									
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll St, Washington, D.C.</u>																					
25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>MAR 10 1967</u>																					



Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

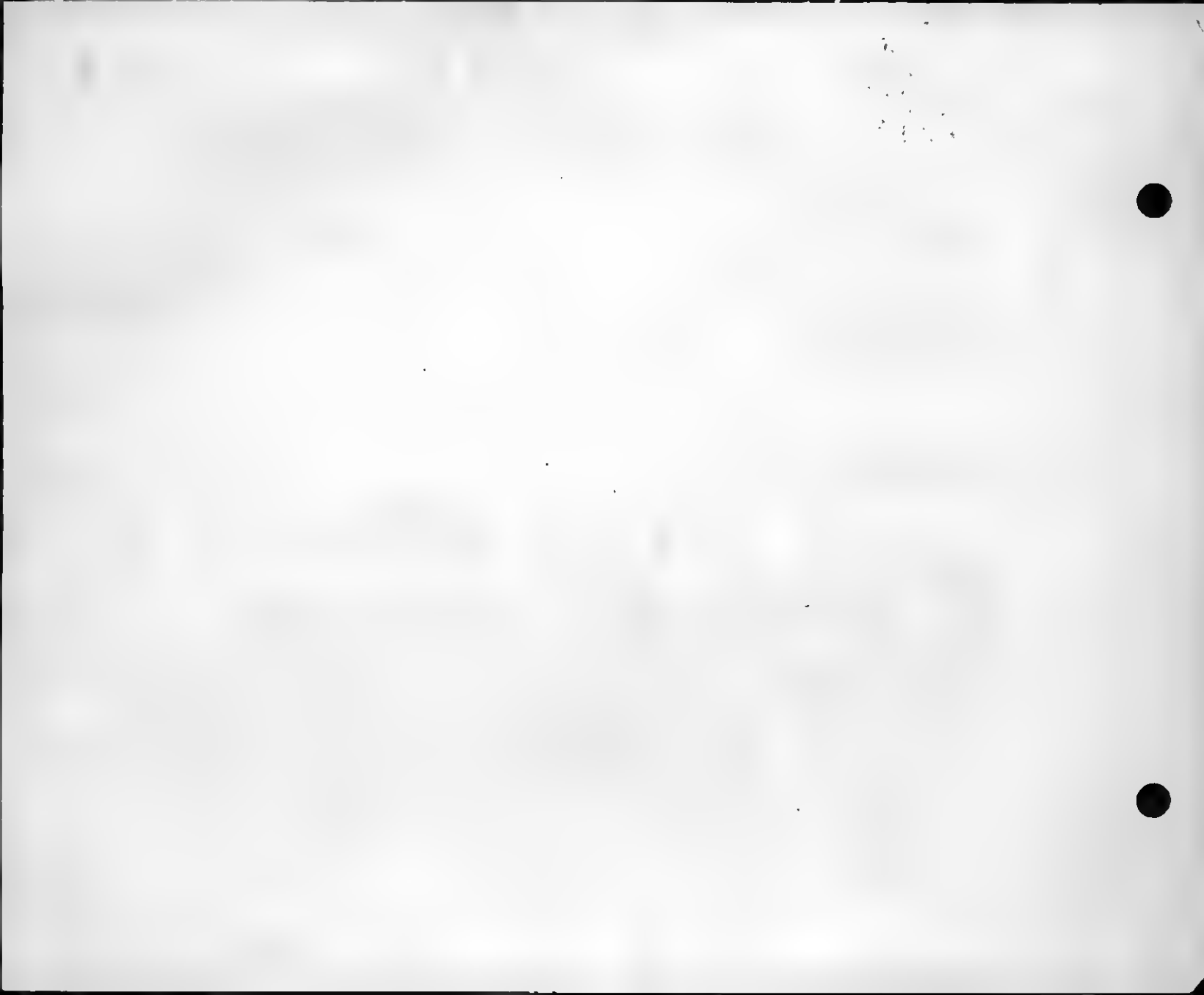
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20 M 1/66

## CERTIFICATE OF DEATH

03977

03976

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
c. LENGTH OF STAY in ib <u>6 weeks</u>		d. STREET ADDRESS <u>329 Quakerbos ST. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RANDOLPH Hills Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Louis</u> Last <u>Wagman</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 15 1888</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery &amp; Liquor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>NATURALIZED U.S.</u>	
13. FATHER'S NAME <u>HIRSH Wagman</u>		14. MOTHER'S MAIDEN NAME <u>Baila RichTa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN -</u>		16. SOCIAL SECURITY NO. <u>577-52-0052</u>	
17. INFORMANT <u>Mishe'l Wagman</u>		Address <u>329 Quakerbos N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1) Shigelliosis 2) Repeated aspiration pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>64</u> , to <u>3/31</u> , 19 <u>67</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>3/31</u> , 19 <u>67</u> , and that death occurred at <u>7:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Norman H. Rubenstein</u>		22b. DATE SIGNED <u>3/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN H. RUBENSTEIN</u>		22d. ADDRESS <u>1161 N.H. Ave. SILVER SPRING, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATHAN HEARD CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>
24. FUNERAL DIRECTOR <u>Goldsberg Funeral Home - Wash. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

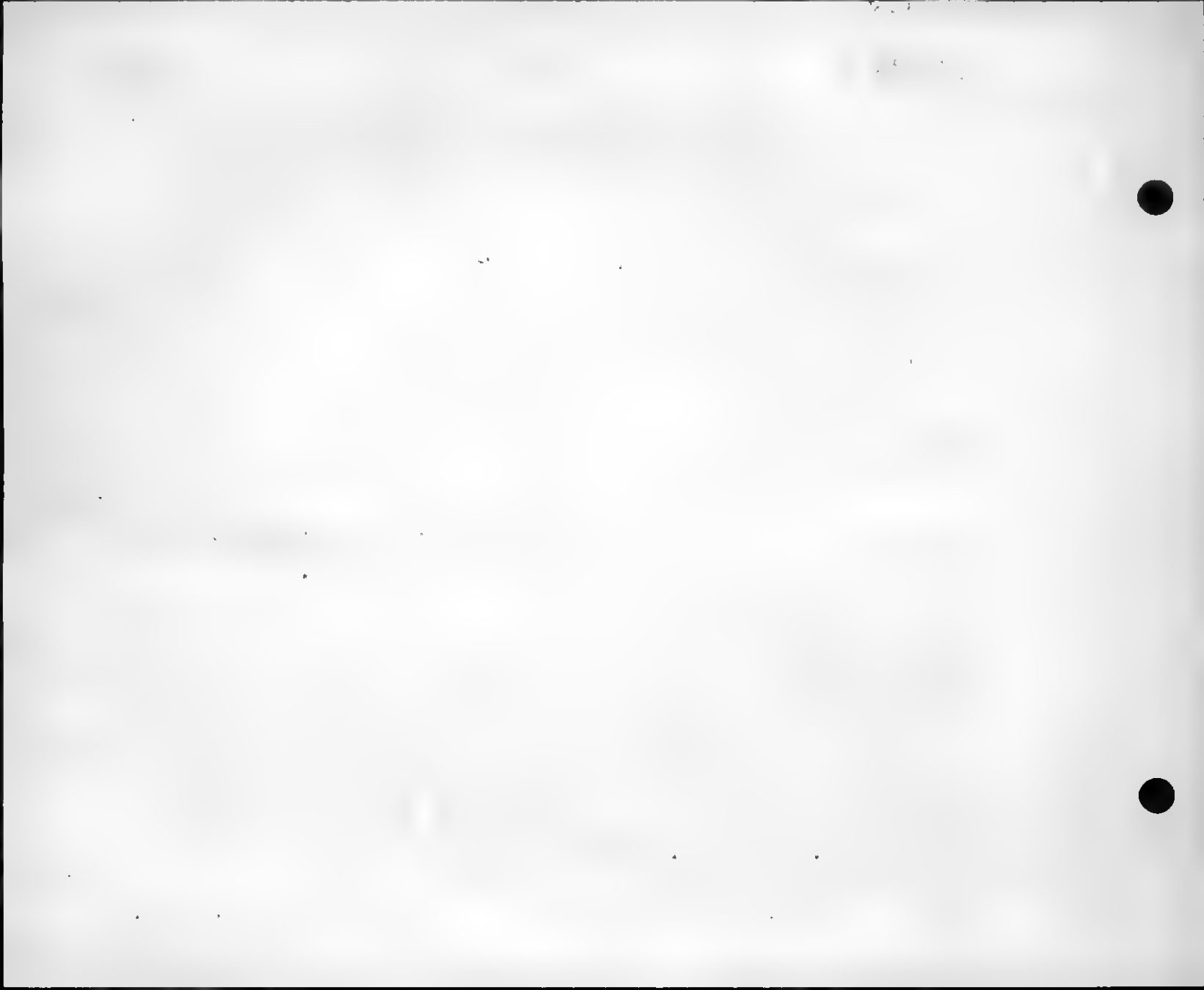
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03978

CERTIFICATE OF DEATH

03977

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>93 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>3600 Cardiff Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise</u> First <u>A.</u> Middle (WALES) Last <u>Weska</u>				4. DATE OF DEATH <u>3-6-1967</u> Month <u>3</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1889</u>	9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan-Paginaw</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Pesenecku</u>				14. MOTHER'S MAIDEN NAME <u>Hennetta Lang</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>220-541224</u>		17. INFORMANT <u>Daughter - Mrs. Floyd E. Samuels, Jr.</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Primary carcinoma of ovary with widespread abdominal and thoracic metastases.</u> DUE TO (c) <u>abdominal and thoracic metastases.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho-pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> , 19 <u>66</u> , to <u>3/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/6</u> , 19 <u>67</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Luther W. Gray</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Luther W. Gray</u>				22d. ADDRESS <u>1302 18th St., N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>3-8-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Roseland Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Royal Oak, Mich.</u>	
24. FUNERAL DIRECTOR <u>Joseph Sauler's Sons</u> ADDRESS <u>Capitol Hill</u>				25a. REC'D BY REGISTRAR <u>9</u> DATE <u>1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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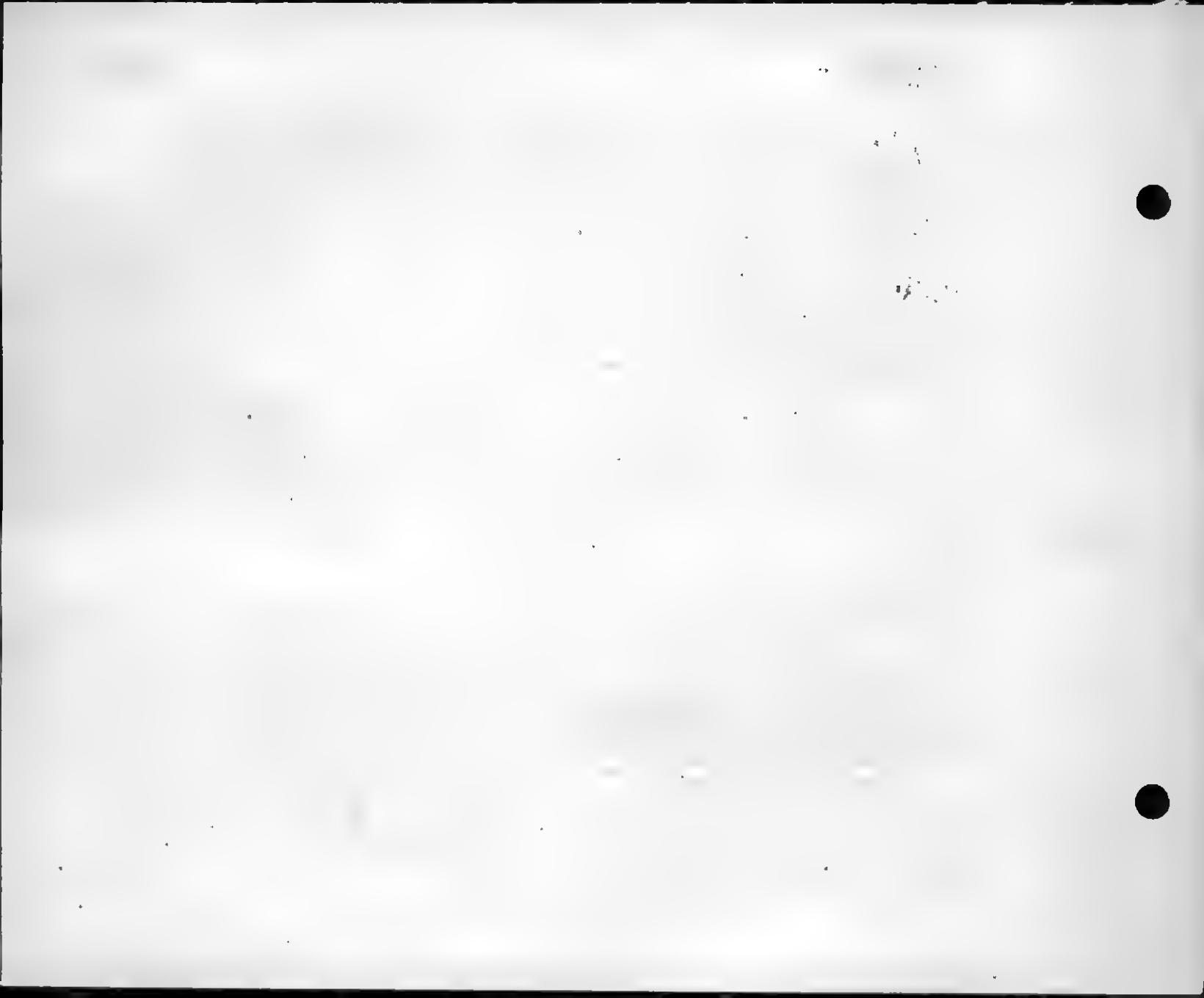
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03979

CERTIFICATE OF DEATH

03978

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>Kentucky</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maysville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		d. STREET ADDRESS <b>400 West 2nd Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Louise</b> Last <b>Walker</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 October 1918</b>
9. AGE (In years lost birthday) <b>48</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John A. Breslin</b>		14. MOTHER'S MAIDEN NAME <b>Martha E. Gaebke</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>293-14-3176</b>	
17. INFORMANT <b>The Medical Records</b>		18. ADDRESS <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of the spleen with / intra-abdominal hemorrhage</b> DUE TO (b) <b>Chronic Myelocytic Leukemia, Blast crisis</b> DUE TO (c) <b>4 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <b>44</b> (this hospital) attended the deceased from <b>28 January, 19 67</b> , to <b>10 March, 19 67</b> , that <b>41</b> (we) lost <b>42</b> the deceased on <b>10 March 19 67</b> , and that death occurred at <b>3:00 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>I. David Goldman</b>		22b. DATE SIGNED <b>10 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>I. David Goldman, MD</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-14-67</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Grave</b>	23d. LOCATION (City or Town) (County) (State) <b>Maysville KY</b>
24. FUNERAL DIRECTOR <b>HANLON Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>4448 W. 1st Ave. N.W.</b>	

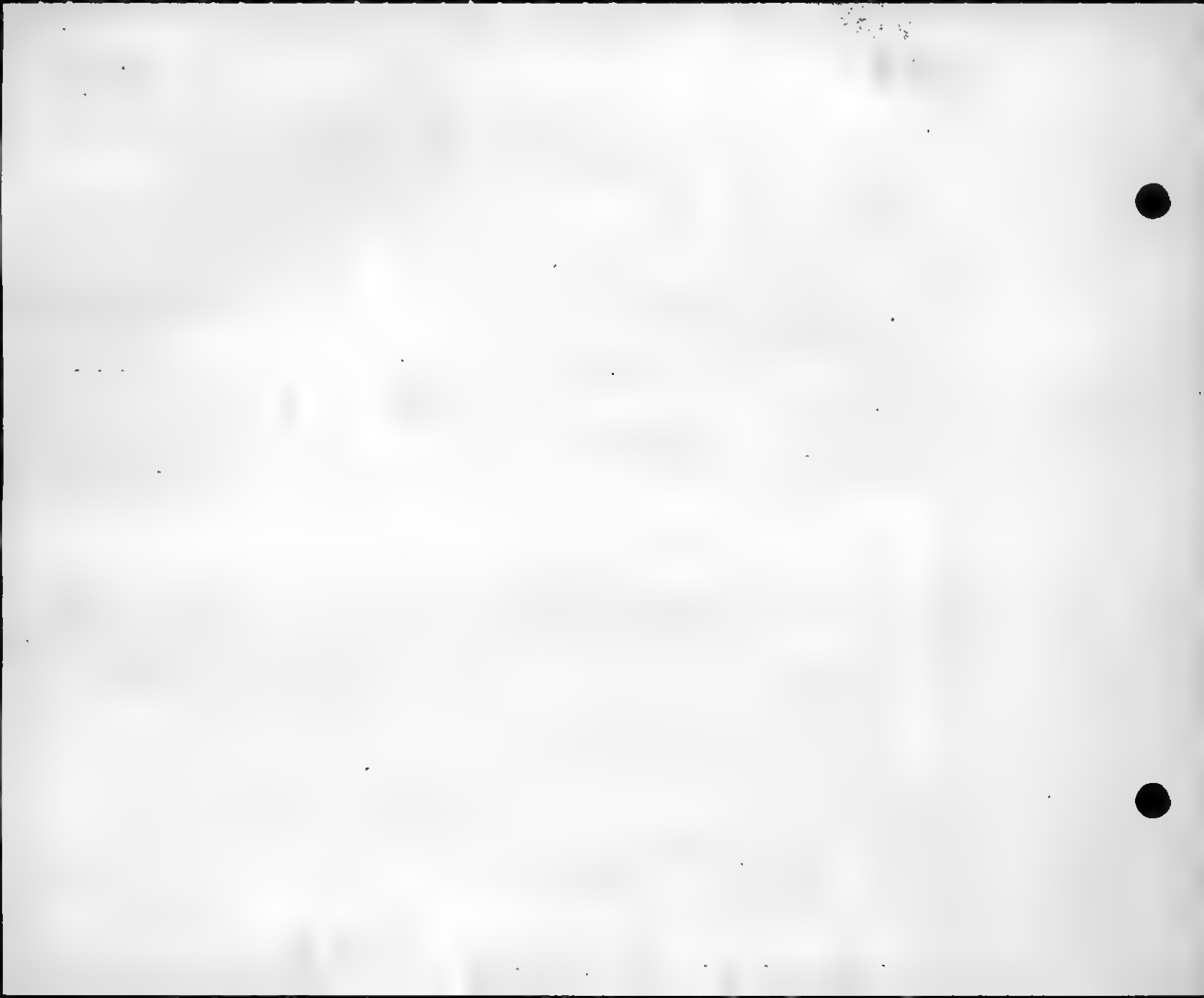




## 13970

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**03981**

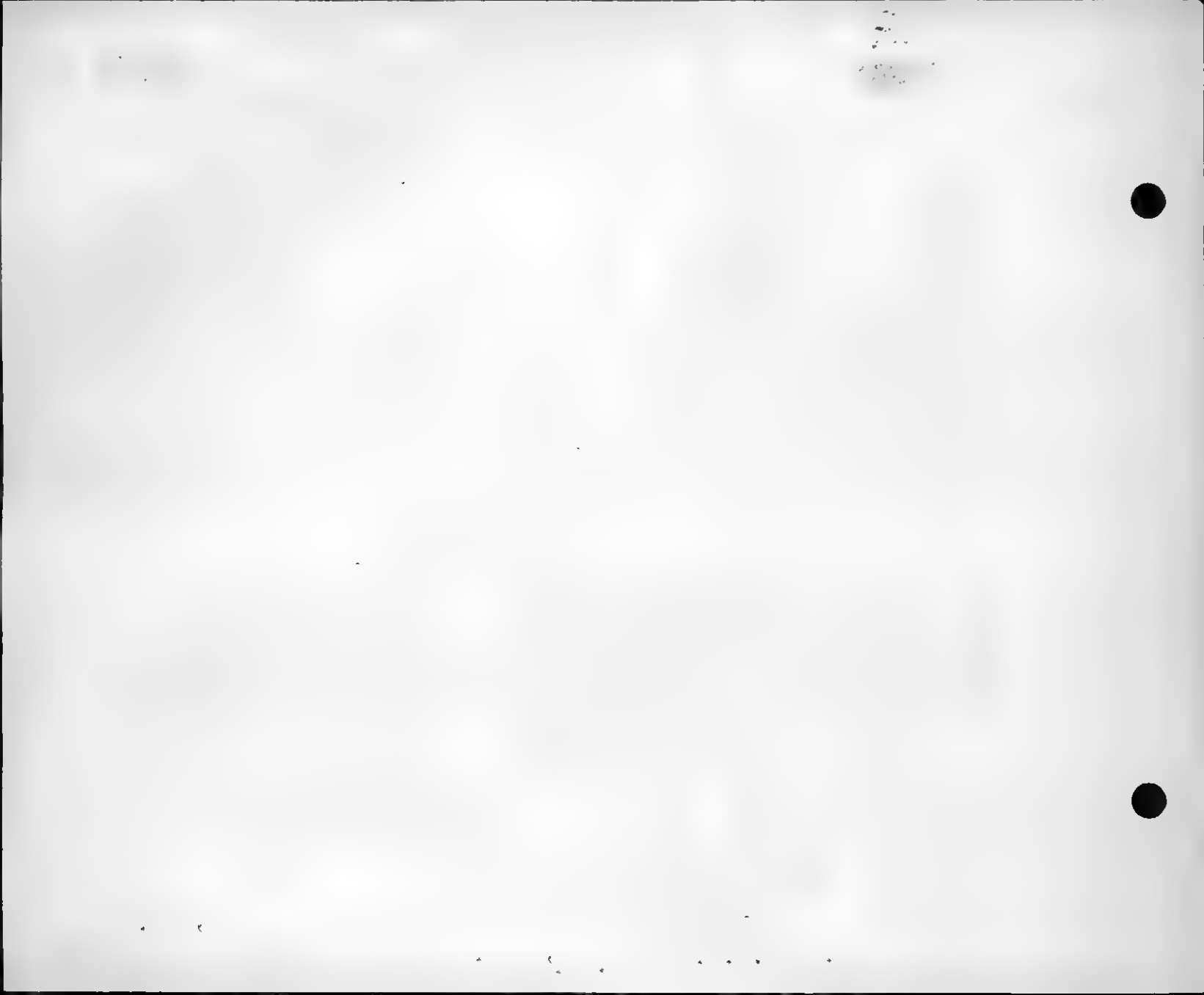
**CERTIFICATE OF DEATH**

**03980**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutor on residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>2 1/2 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>Colonial Villa Nursing Home</u> <u>1571</u> <u>New Hampshire Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Della</u> <u>(None)</u> <u>Wall</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>22</u> <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/81</u>		9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>US America</u>	
13. FATHER'S NAME <u>Isiah Wall</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Strange</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>313-40-3559</u>		17. INFORMANT <u>Medical records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast</u> (c) <u>Since 1956</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1967</u> to <u>Mar 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 22, 1967</u> , and that death occurred at <u>7:50 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond O. West</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3-23-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md</u>	
24. FUNERAL DIRECTOR <u>Joseph Carler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W.</u> <u>Wash. DC.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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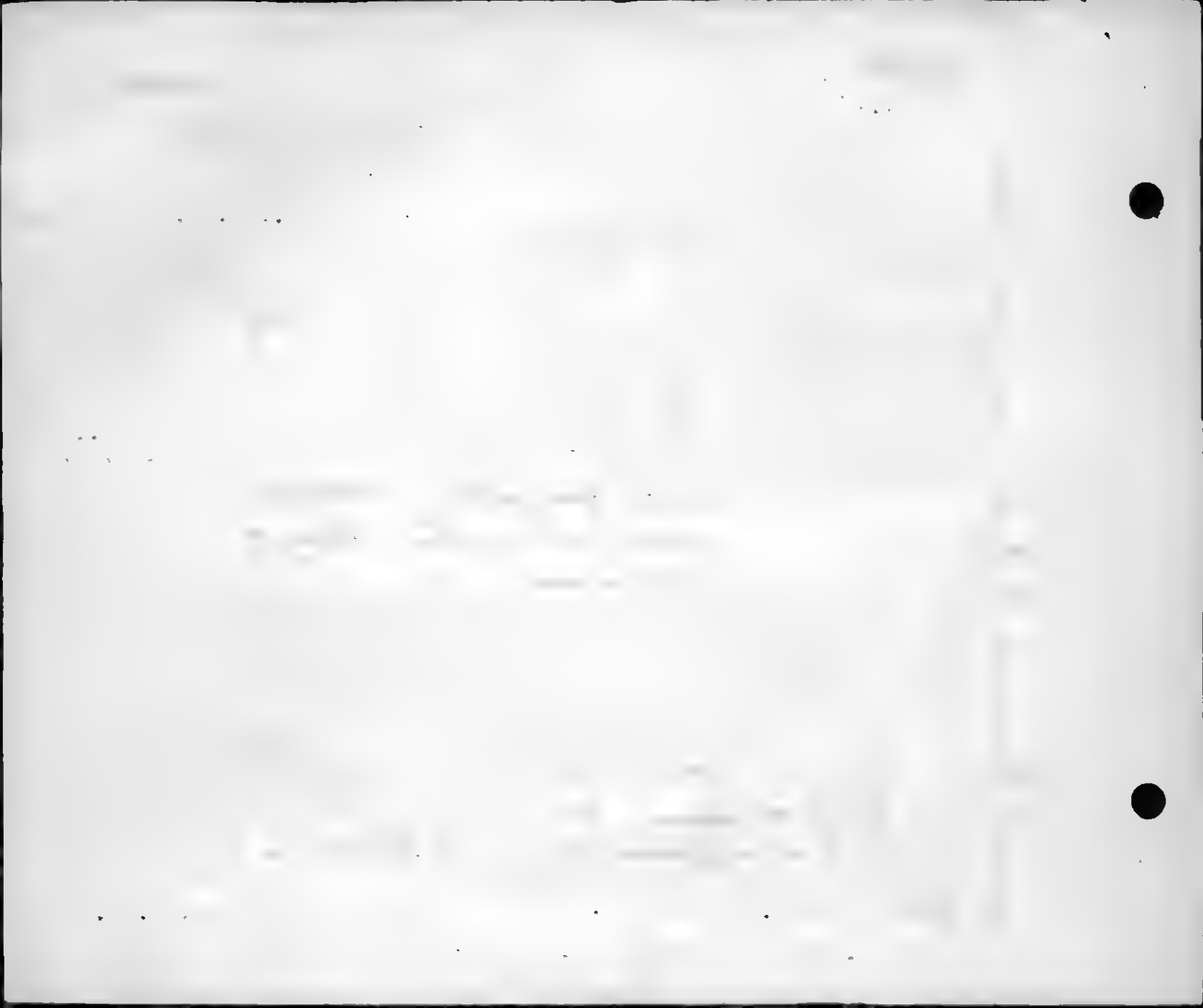


03484

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
25M 1/67

Medical Examiner Dr. Ball not present & cleared. Fur



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. M

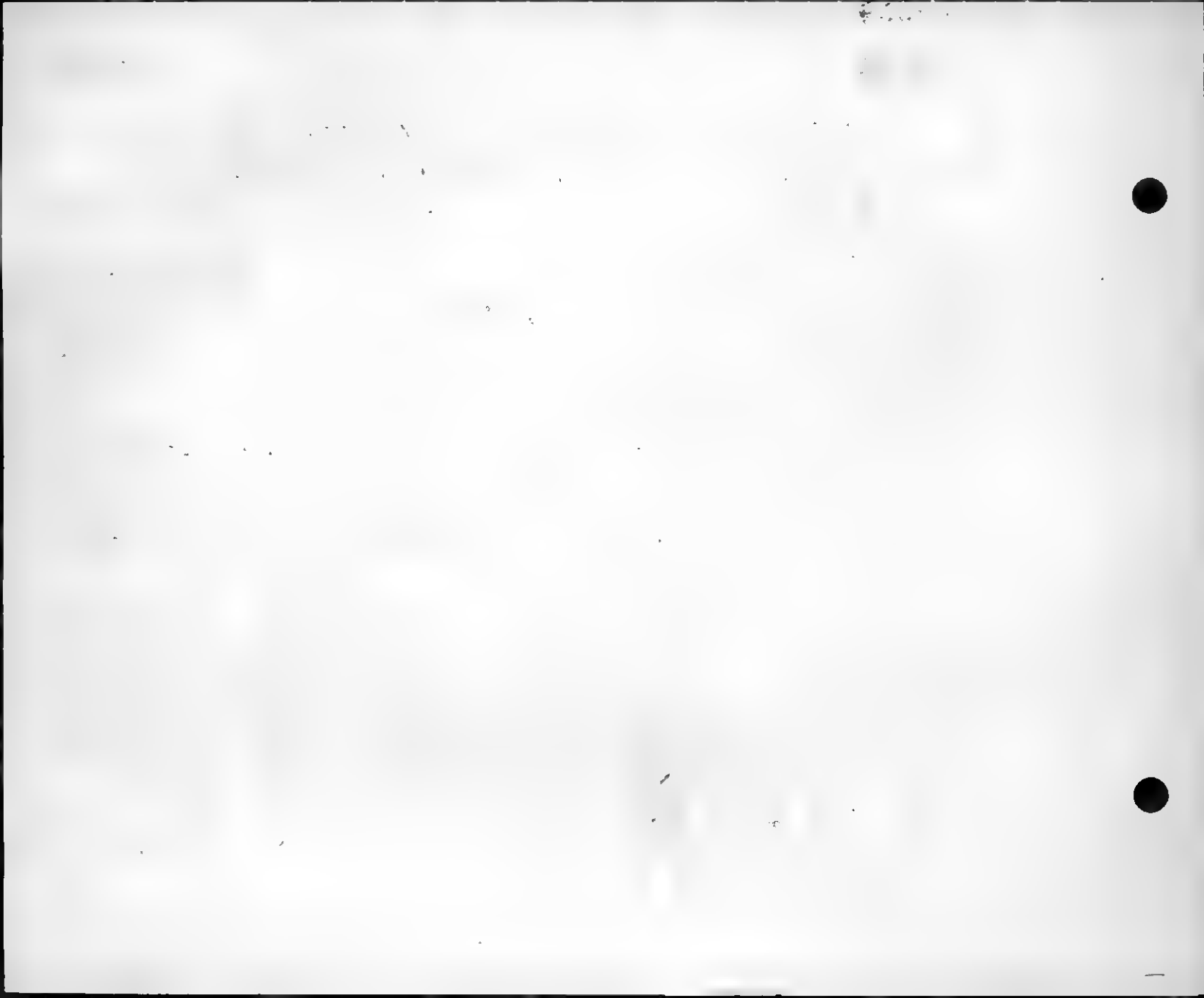
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03983

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03982

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(R) Barnesville</u>				c. LENGTH OF STAY IN 1b <u>years.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 109.</u>				e. STREET ADDRESS <u>Route 109.</u>			
3. NAME OF DECEASED (Type or print) <u>Reginald Eugene Ward</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1914</u>	9. AGE (In years last birthday) <u>52</u> yrs.	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u>19</u> Min.		11. IF UNDER 74 HRS Months <u>1</u> Days <u>17</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Charles H. Ward</u>				14. MOTHER'S MAIDEN NAME <u>Addie Bennett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-05-7051</u>		17. INFORMANT <u>Sister Eleanor Ward</u> Address <u>Barnesville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intrication of cerebral vessels -</u> DUE TO <u>1071</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>congenital defect of blood vessel.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/21/67</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d. LOCATION (City or town) (County) (State) <u>Barnesville Montz Md</u>	
24. FUNERAL DIRECTOR <u>William C. Hiltz, Barnesville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





Cleared with Dr. J. Ball for Dr. Sterling to sign

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

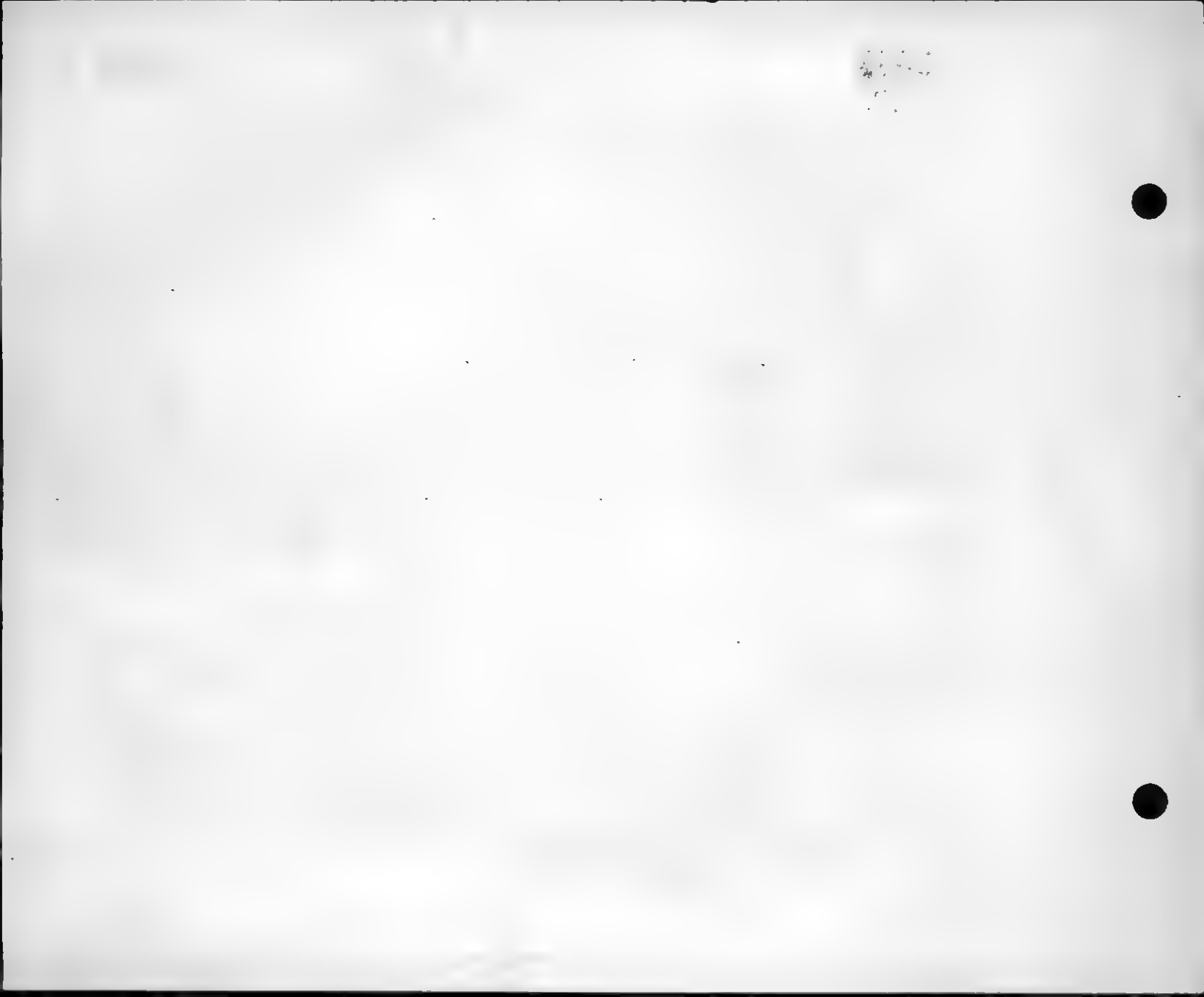
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03984

CERTIFICATE OF DEATH

03983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Forrester Paul Weinstock</u>		4. DATE OF DEATH Month Day Year <u>March 3 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 2, 1907</u>
9. AGE (in years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - Delia. FOOD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Weinstock</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Zupnik</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>577-20-8714</u>		17. INFORMANT <u>wife SAME AS 20</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE 10 YRS.</u> DUE TO (c) <u>CEREBRAL HEMORRHAGE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>D. OBSTRUCT &amp; OLD MYOCARD. OL INFARCTION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>3-3</u>		20f. (City or town) (County) (State) <u>3-3</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 13, 1958</u> to <u>3-3, 1967</u> , that (I) (we) last saw the deceased alive on <u>FEB 27 1967</u> , and that death occurred at <u>12:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel Weinstock</u>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOEHL STERN (M.D.)</u>		22d. ADDRESS <u>852-4th. Bldg. WASHINGTON</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-6-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NATHL MEM. PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA</u>	
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>945014</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 7 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03985

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence and death certificate) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1500 Forest Glen Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Weiss</u> Last <u>Weiss</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3.4.88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>79</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Morris Weiss</u>		14. MOTHER'S MAIDEN NAME <u>Laura Dinowitz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Morris Weiss</u> Address <u>9039 Silver Spring Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wernia due to acute nephrosis</u> 7X DUE TO (b) <u>Obstructive jaundice</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Carcinoma of head of pancreas</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>5 wks</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25</u> , 19 <u>67</u> , to <u>March 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar. 30</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen, M.D.</u>		22b. DATE SIGNED <u>3-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST, SILVER SPRING</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cem. (old)</u>	23d. LOCATION (City or Town) (County) (State) <u>Springfield, L.I. N.Y.</u>
24. FUNERAL DIRECTOR <u>B. Naryansky &amp; Sons</u>		25. REC'D BY REGISTRAR <u>APR 3 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03986

**CERTIFICATE OF DEATH**

03985

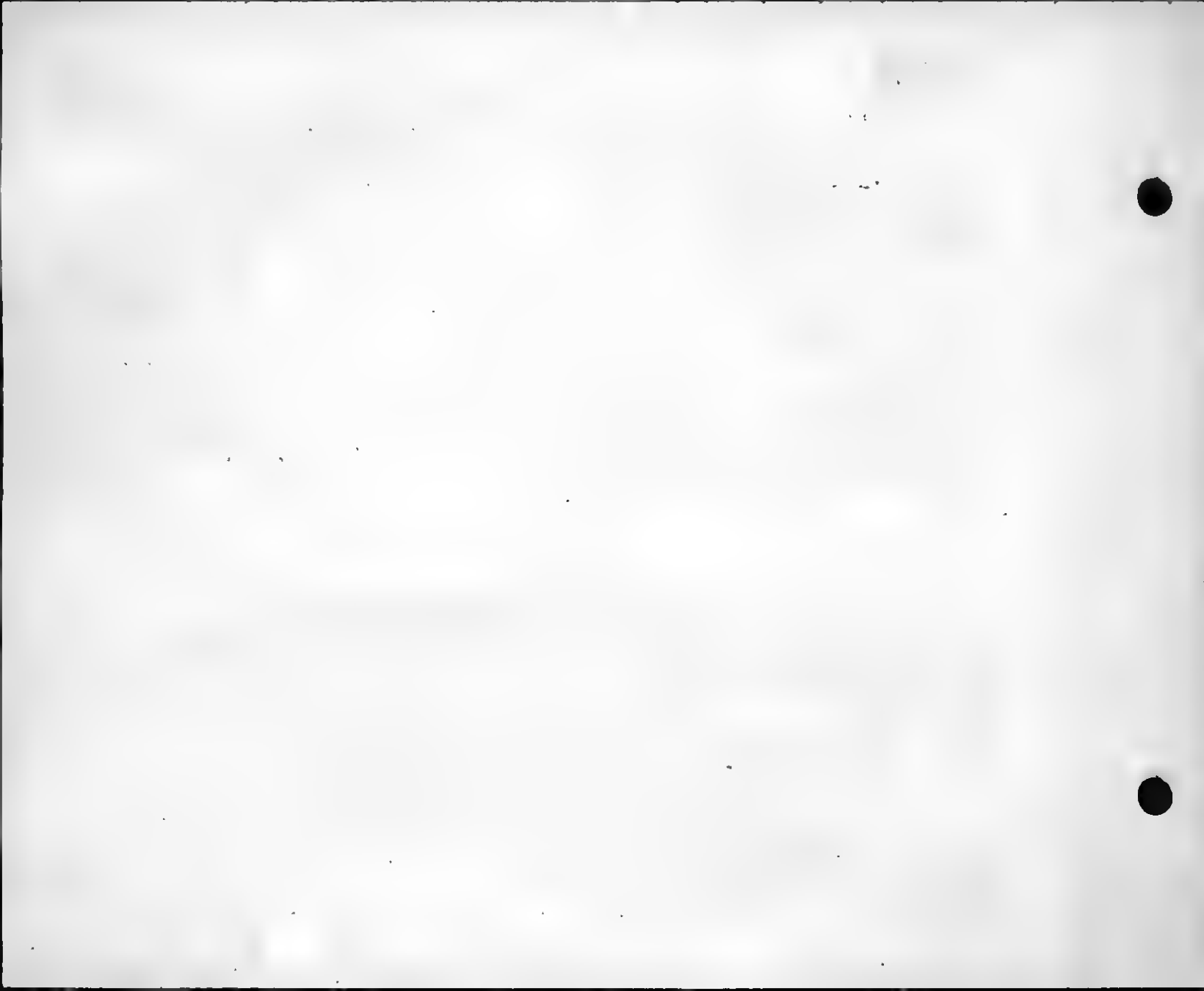
1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY in 1b <u>1 day</u>				d. STREET ADDRESS <u>2309 Ross Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Sophie</u> Middle <u>Agnes</u> Last <u>WENDT</u>		4 DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1967</u>					
5. SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>March 8, 1905</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Politoski</u>				14. MOTHER'S MAIDEN NAME <u>Anna Baranczok</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>399-14-3480</u>		17 INFORMANT <u>Patricia Jacoby</u> Address <u>2309 Ross Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID Hemorrhage</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Essential Hypertension</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>21 hours</u> <u>5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1965</u> , to <u>MARCH 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 2, 1967</u> , and that death occurred at <u>9:47 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Max G. Sherer</u>				22b. DATE SIGNED <u>3/2/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u>				22d. ADDRESS <u>800 PERSHING Drive Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>March 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Adalberts Catholic Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Milwaukee, Wisconsin</u>	
24 FUNERAL DIRECTOR <u>Glen Carter</u> ADDRESS <u>8434 Georgia Ave.</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CLEARED BY MEDICAL EXAMINER

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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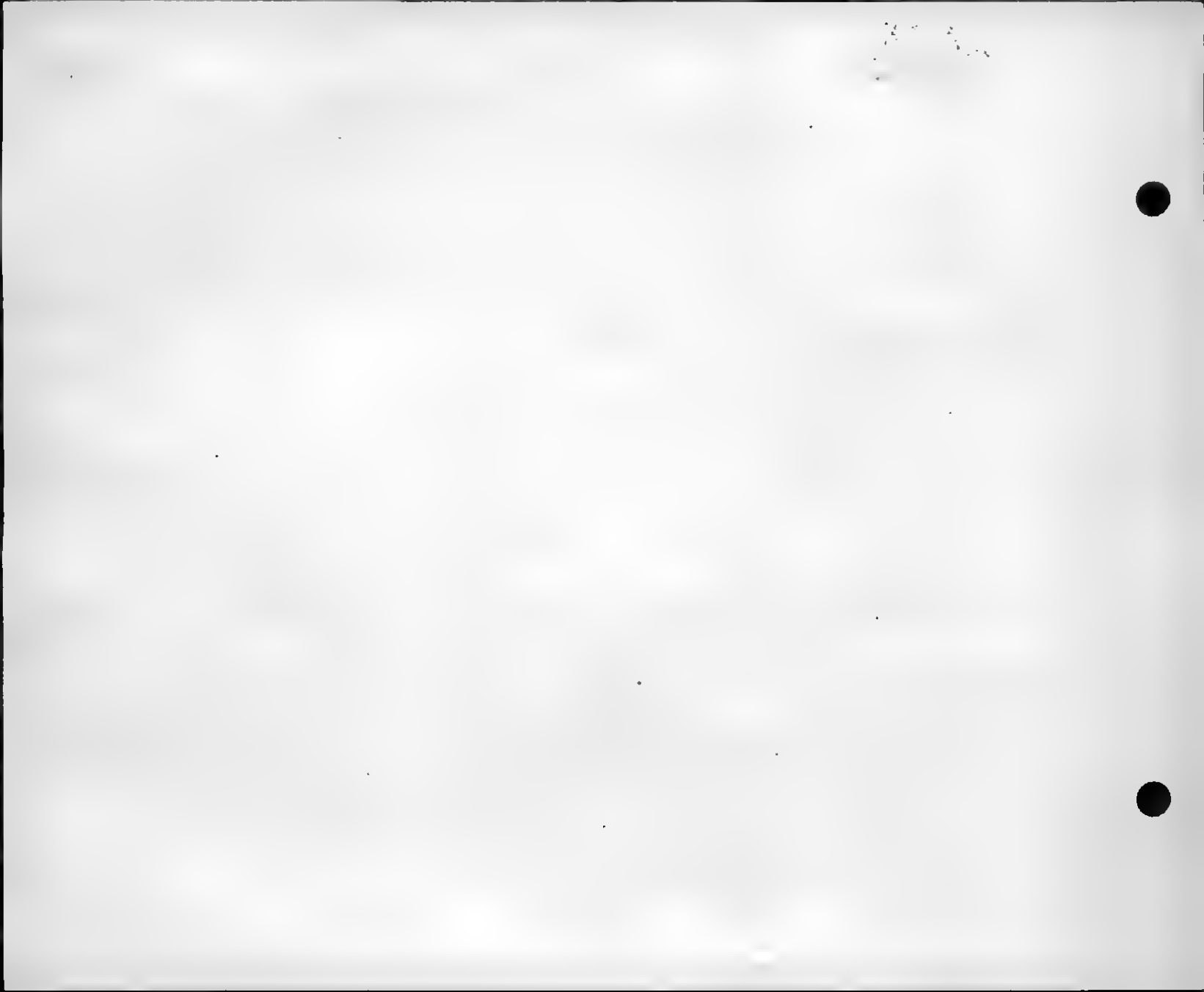
MD  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

03987

**CERTIFICATE OF DEATH**

03986

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>		c. LENGTH OF STAY in 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown RFD.</u>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>KATIE</u> Middle <u>A</u> Last <u>WERNER</u>		4 DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 8 - 1896</u>
		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>German</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13 FATHER'S NAME <u>Lorena Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>114-18-3866</u>	
		17. INFORMANT <u>Carl Werner, Germantown Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4000</u> DUE TO <u>ACUTE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>3 YEARS</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>17 Jan</u> , 1967, to <u>31 March</u> 1967, that (I) (we) last saw the deceased alive on <u>30 MARCH</u> 1967, and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Lawrence</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/31/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>See Crematorium</u>		23d. LOCATION (City or Town) (County) (State) <u>W.H.S. D.C.</u>	
24. FUNERAL DIRECTOR <u>William B. Wilson, Barnesville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03988

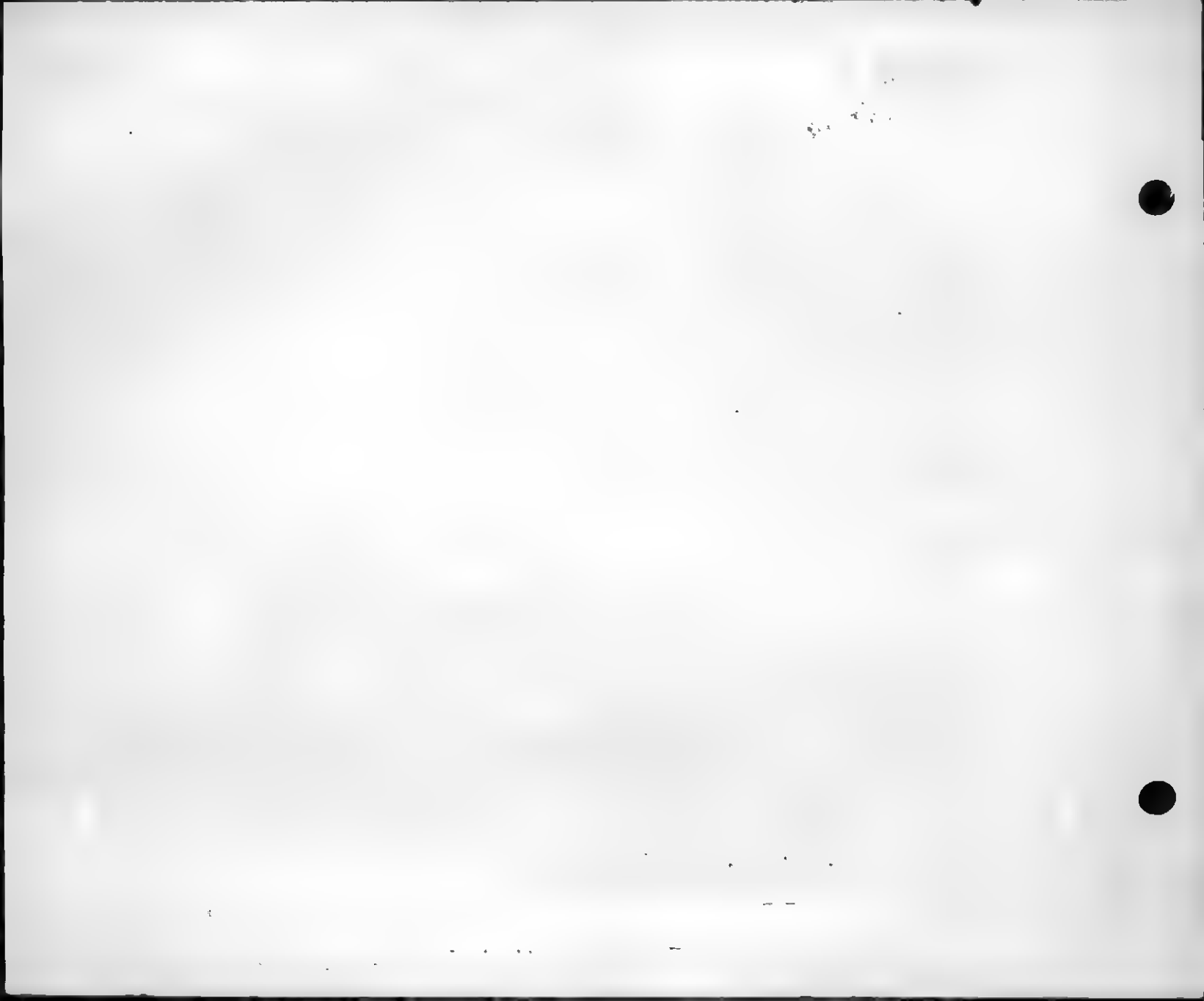
CERTIFICATE OF DEATH

03987

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Rt #1 Box #33</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Grace - Mildred - West</u>				4. DATE OF DEATH <u>March 1 1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>Negro</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B DATE OF BIRTH <u>4/21-1900</u>	
8 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Stafford County - Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Richard Good</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ballard</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO <u>577-12-8251</u>		17. INFORMANT <u>Ref. Julian West - 5814 3rd St - NW DC.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>6000</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diagnosis of acute myocardial infarction</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 5, 1966</u> to <u>March 1, 1967</u> that (I) (we) last saw the deceased alive on <u>3/1</u> 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>John D. Mayloth</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John D. Mayloth</u>				22d. ADDRESS <u>50 W. Edmonston Dr. Rockville Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24 FUNERAL DIRECTOR <u>John T. Rhines &amp; Company - 3015 12th St., N. E.</u>				25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03989

## CERTIFICATE OF DEATH

03988

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>56 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		d. STREET ADDRESS <b>7709 Lorton Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Israel</b> Middle <b>McKinley</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1938</b>
9. AGE (In years last birthday) <b>28</b> yrs		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Burner Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Bossie Williams</b>		14. MOTHER'S MAIDEN NAME <b>Violet Walters</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>	
17. INFORMANT <b>The Medical Records</b>		18. ADDRESS <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hemorrhage pneumonitis right lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  <b>3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peptic Ulcer - 6 months</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>16 January, 1967</b> , to <b>13 March, 1967</b> , that <b>(X)</b> (we) lost saw the deceased alive on <b>13 March 1967</b> , and that death occurred at <b>8:00 M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Leonard H. Brubaker</b>		22b. DATE SIGNED <b>13 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leonard H. Brubaker, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Front Royal, Warren Va.</b>
24. FUNERAL DIRECTOR <b>Scott Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 15 (4)  
M 1/68

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

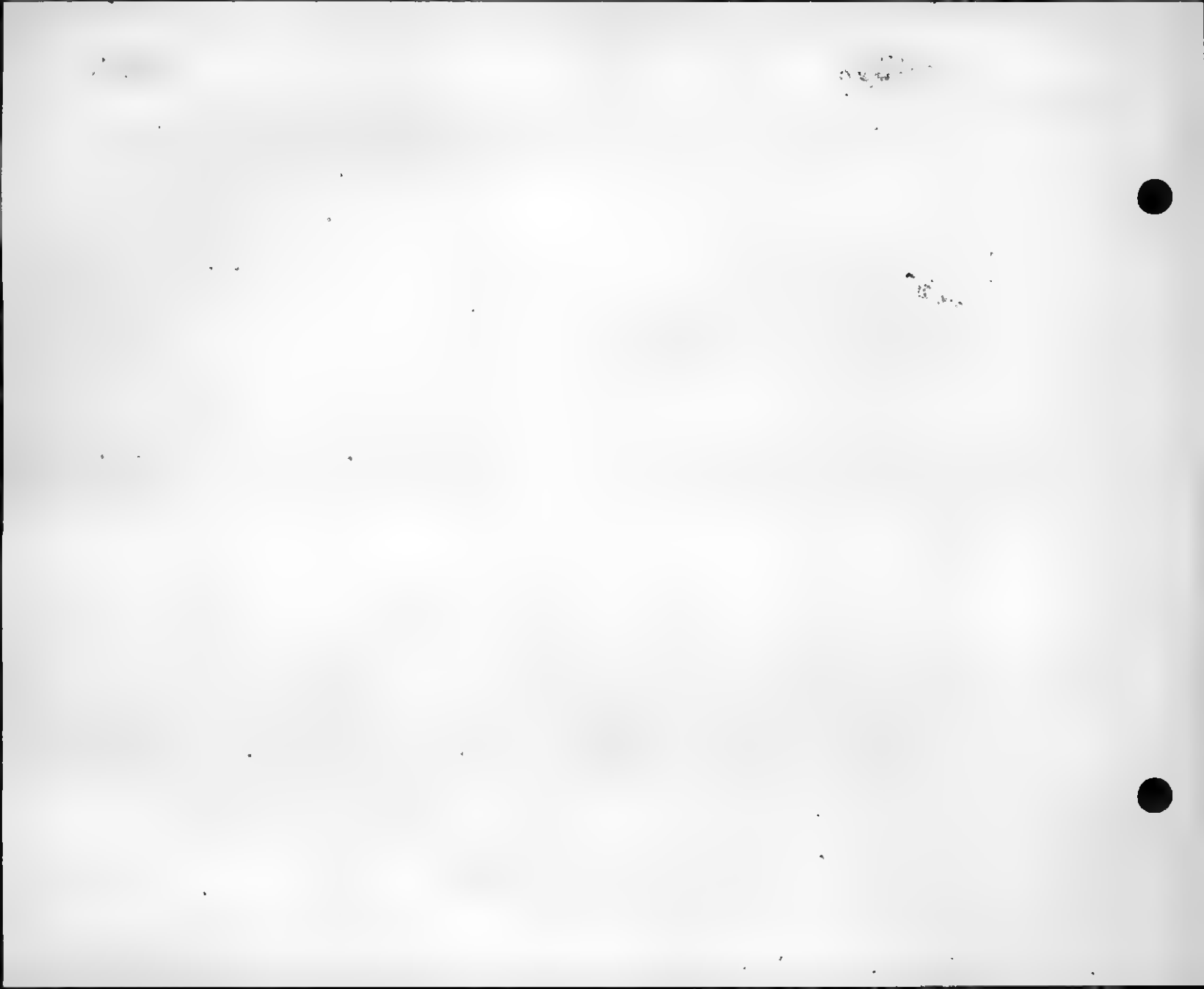
MARYLAND STATE DEPARTMENT OF HEALTH

03990

CERTIFICATE OF DEATH

03989

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>Hall Shop Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Alice</b> First Middle Last		4. DATE OF DEATH <b>Mar. 31 19 67</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-86</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Allen Peters</b>		14. MOTHER'S MAIDEN NAME <b>Alice Hoffman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>214-38-8102</b>	
17. INFORMANT <b>Montgomery Gen. Hospital</b> Address <b>Olney, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>35ix</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>EB. 28, 1967</b> , to <b>MAR. 31, 1967</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred on <b>24 5am</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles S. Whitaker</b> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles Whitaker</b>		22d. ADDRESS <b>ELLICOTT CITY, MARYLAND</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-3-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST MARKS</b>	23d. LOCATION (City or Town) (County) (State) <b>Highland Md.</b>
24. FUNERAL DIRECTOR <b>Wynnebell Jones - FUN. HOME</b> ADDRESS <b>ELLICOTT CITY</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

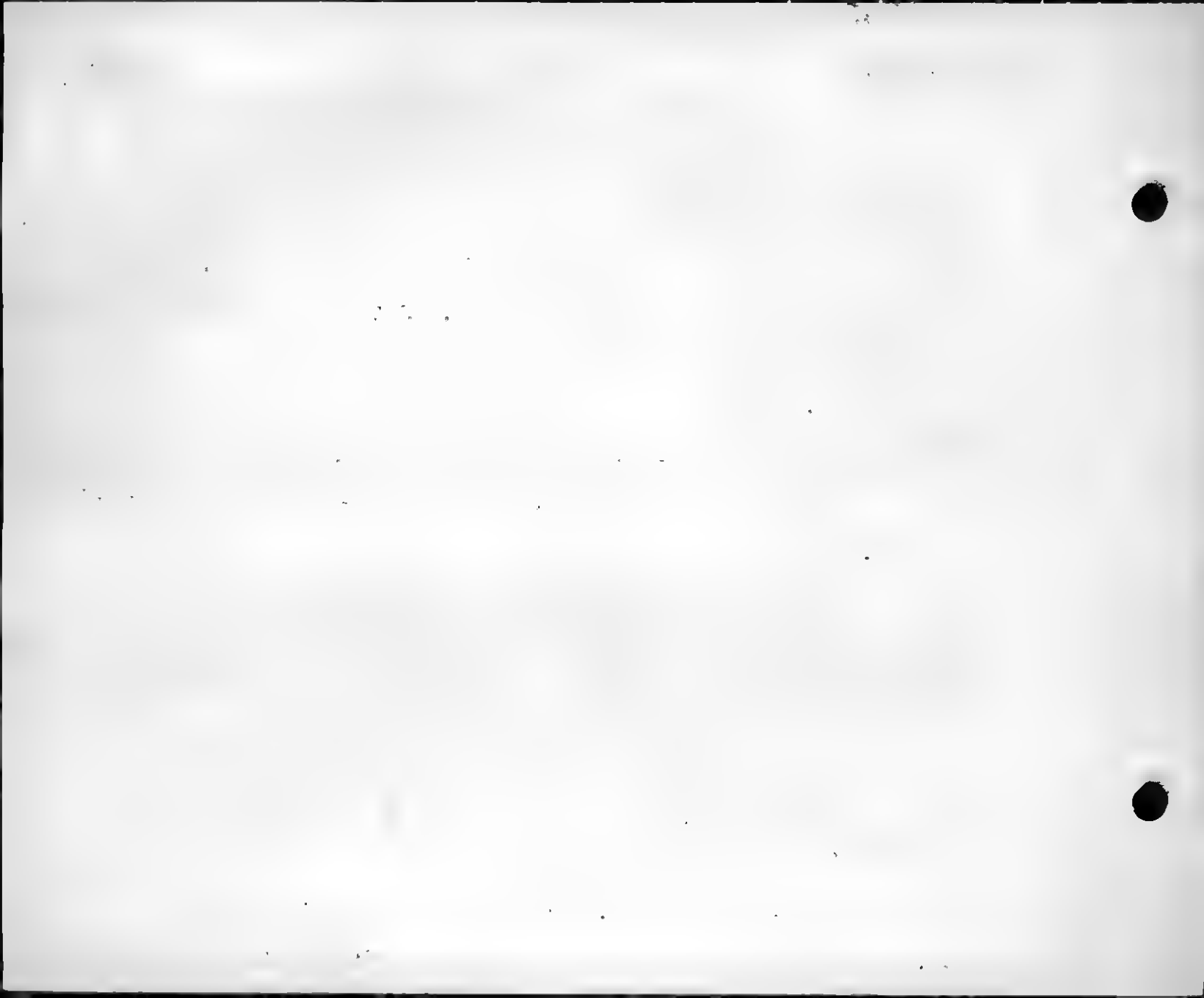
**03991**

**03990**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Rachael</u> Middle <u>Arnell</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>2</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 23, 1875</u>		
				9. AGE (In years lost birthday) <u>91 yrs</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Horace P. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Wilson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO <u>217-40-6834 A</u>		17. INFORMANT <u>Sheridan Wilson, The Oaks, Ellicott City, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary sclerosis</u>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)		
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>July</u> , 19 <u>46</u> , to <u>3/2</u> , 19 <u>67</u> , that (I) <u>was</u> just saw the deceased alive on <u>3/1</u> , 19 <u>67</u> , and that death occurred at <u>7:15 am</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>Charles S. Whitaker</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles Whitaker</u>				22d. ADDRESS <u>CLARKSVILLE, M.D.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-4-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		23d. LOCATION (City or Town) (County) (State) <u>Highland, Md</u>		
24. FUNERAL DIRECTOR <u>E. C. Higinbotham</u> <u>Ellicott City, Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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26

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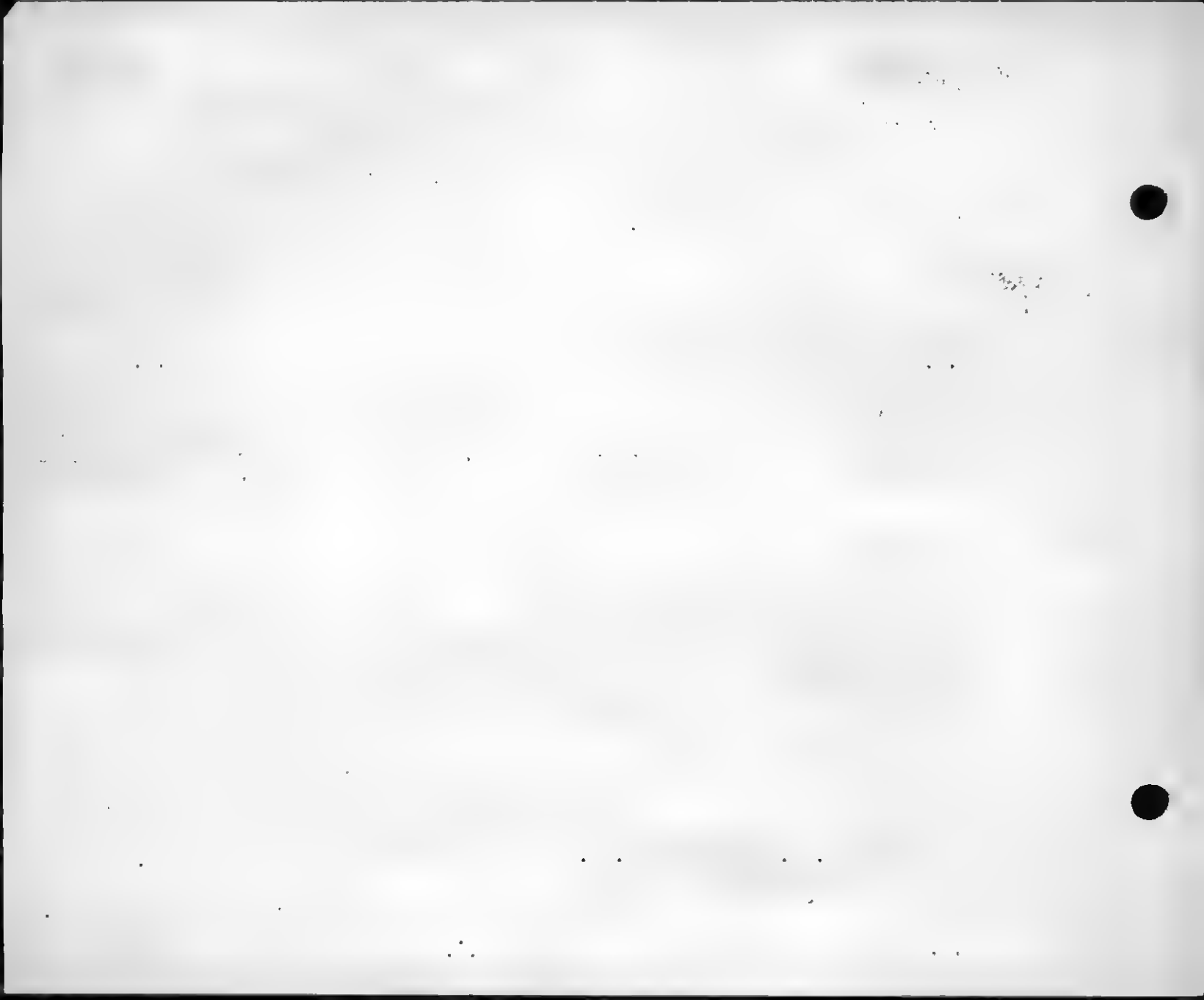
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2a,b,c & d Film 347 3/28/67 pc

03992

CERTIFICATE OF DEATH

03991

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> Ala. b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Naval Hospital</b>		c. LENGTH OF STAY IN TB <b>164</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Birmingham Marine Corps Schools, Quantico</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>Quarters/4703B/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Charles</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 Oct 1930</b>		9. AGE (In years last birthday) yrs <b>36</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ernest (n) WILSON</b>				14. MOTHER'S MAIDEN NAME <b>Ettalowe WILLIAMS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>417-32-2082</b>		17. INFORMANT <b>Mrs. Louise WILSON</b> Address <b>Quarters 4703B Marine Corps School, Quantico Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA</b> <b>2001</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>27 Sep 1966</b> to <b>10 Mar 67, 19</b> , that (we) last saw the deceased alive on <b>10 March 1967</b> , and that death occurred at <b>11:45 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>D. R. Foreman</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12 March 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. R. Foreman M. D.</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Funeral Home</b>		ADDRESS <b>1400 Chapin St. NW Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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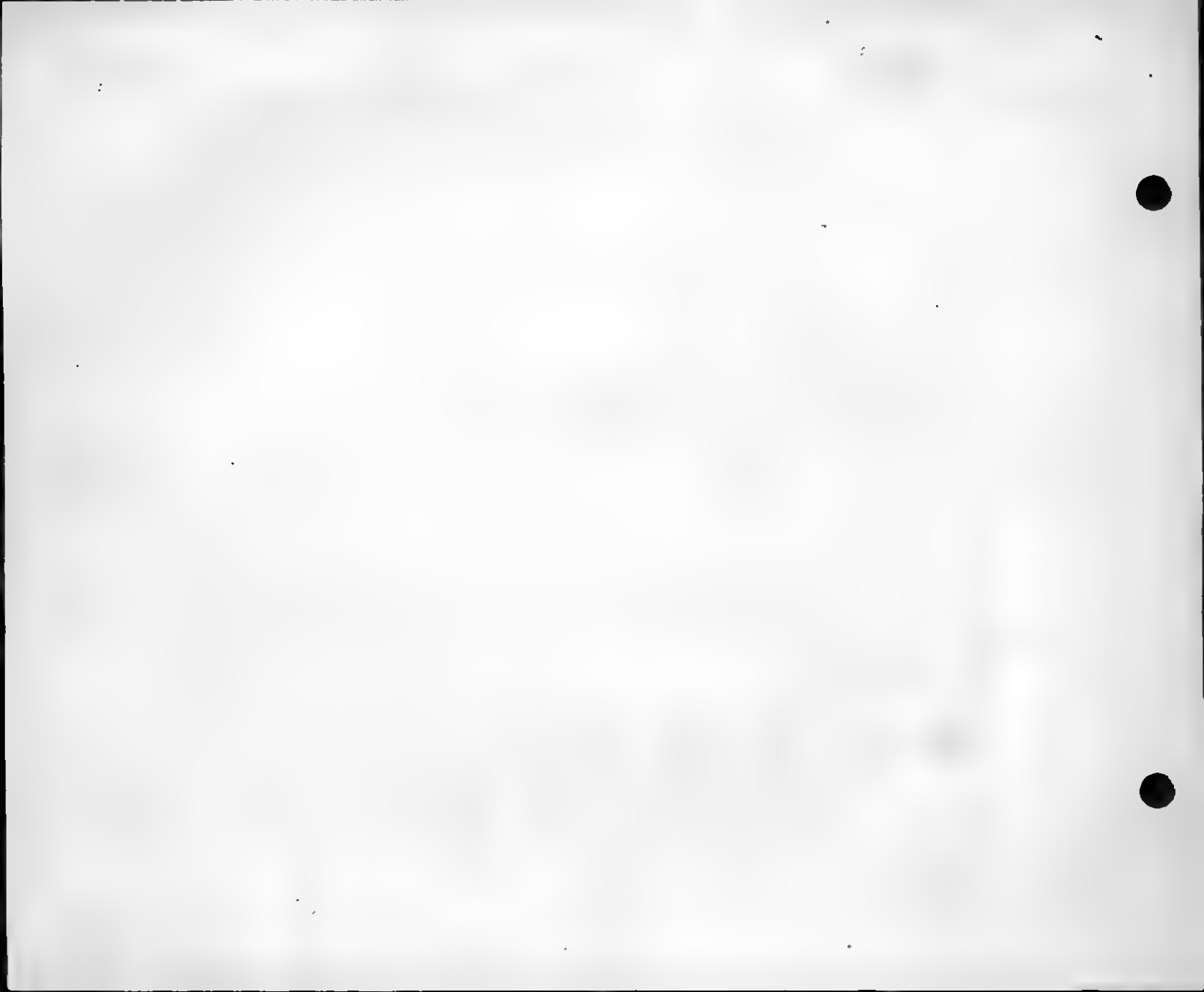
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03993

CERTIFICATE OF DEATH

03992

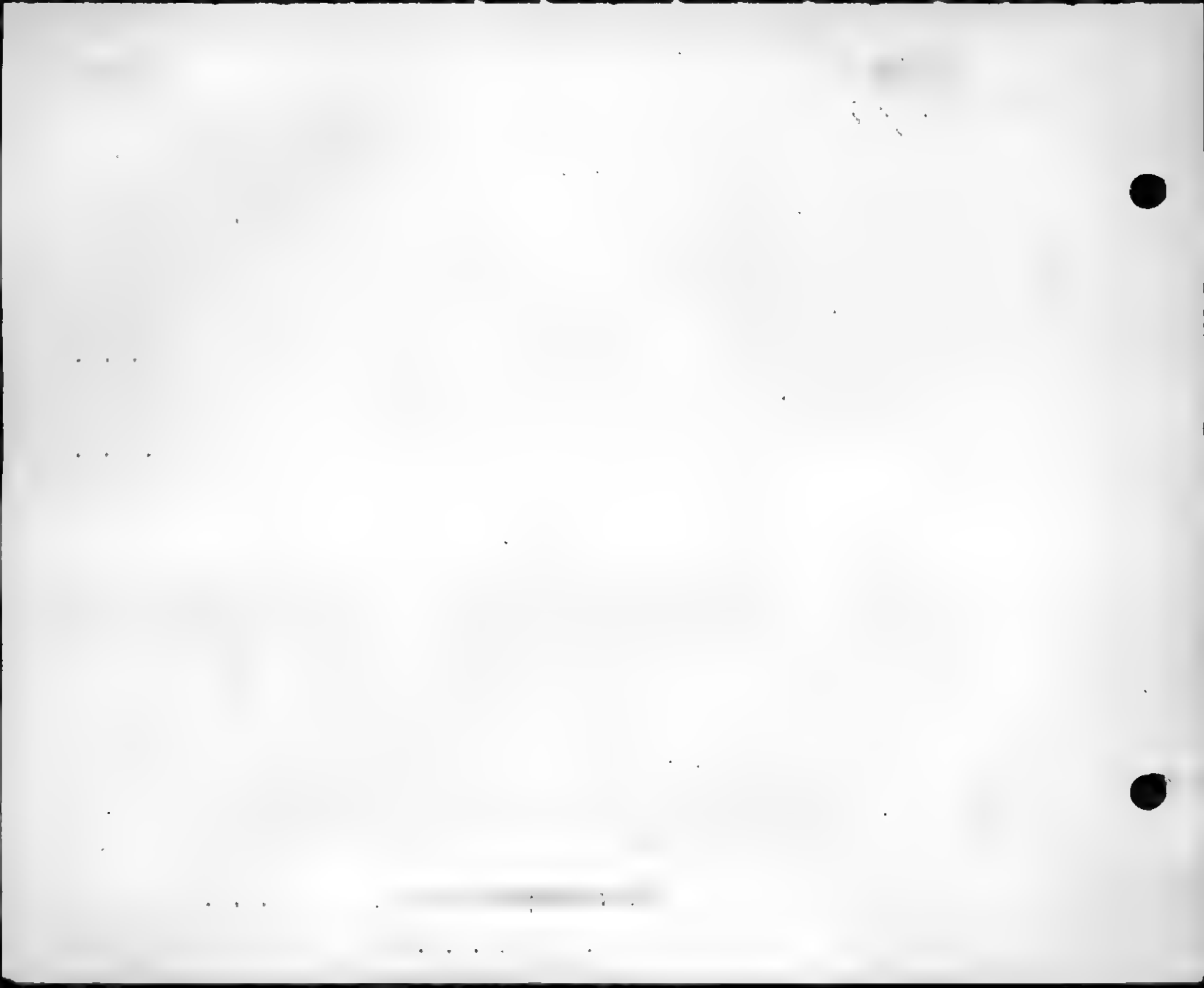
1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>26 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pastorville</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lickhurn</u>				d STREET ADDRESS <u>Route 1</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bert Butler Wolfrey</u>				4. DATE OF DEATH Month Day Year <u>March 24 1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-99</u>	9 AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 Year Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret.) <u>Coca Cola Plant - Silver Spring</u>			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Wolfrey</u>				14. MOTHER'S MAIDEN NAME <u>Wilmonia Minnick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>World War II</u>		16. SOCIAL SECURITY NO <u>577-42-9984</u>		17. INFORMANT <u>Mrs. William J. Wolfrey - 19 MacArthur Drive</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Colonic fistula</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 26, 1967</u> , to <u>Mar. 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar. 24, 1967</u> , and that death occurred at <u>7:55 P.M.</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Louis R. Perna</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Mar. 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Louis R. PERNA, M.D.</u>				22d. ADDRESS <u>1746 K. ST. N.W. Wash., D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Beallsville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>30</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
03994		03993							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs 2 Mos. 4 days</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>305 Dearborn Ave.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wolin</u> Last <u>Wolin</u>					4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 25, 1892</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Wolin</u>					14. MOTHER'S MAIDEN NAME <u>Esther</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>579-10-3936</u>				
					17. INFORMANT <u>Nathan Wolin, 1835 Tulip St., N.W.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/10, 1967</u> to <u>3/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>3/7, 1967</u> , and that death occurred at <u>4:30 P.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Boris Rabkin</u>					22b. DATE SIGNED <u>3/12/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>					22d. ADDRESS <u>1019 New Blvd East</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>3/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elesavetgrad Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Wash.D.C.</u>		
24. FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons St.NW, Wash.D.C.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
MAR 15 1967									



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

03995

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03994

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>2 1/2 Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9312 Win Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jora</u> Middle <u>Elizabeth</u> Last <u>York</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12-07-59</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>
11. BIRTHPLACE (State or foreign country) <u>Grede County, NC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Dinger</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Klutz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unobtainable</u>	
17. INFORMANT <u>Daughter - Mrs John G. Vicens</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <u>3/14/1967</u>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/>		23b. DATE THEREOF <u>March 17, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grede Mem. Park</u>		23d. LOCATION (City or town) (County) (State) <u>Grede County, North Carolina</u>	
24. FUNERAL DIRECTOR <u>C. G. Carter</u> <u>Warner E. Pumphrey, Inc. 8434 Ga. Ave. Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>	

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5/14/72

RECEIVED  
MAY 14 1972  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03996						03995					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u> c. LENGTH OF STAY IN 1b <u>151</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8007 MacArthur Blvd</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u> d. STREET ADDRESS <u>8007 MacArthur Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>FRANCES V. ZELLER</u>			4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9-19-1882</u>			9. AGE (in years last birthday) <u>84</u> yrs.			10. FINDER 1 YEAR <input type="checkbox"/> FINDER 24 HRS. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>August Voehl</u>			14. MOTHER'S MAIDEN NAME <u>Hildegard Heider</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>01982 Long Sam LAS. 2.D.</u>		
17. INFORMANT <u>Olga Z. Long Sam LAS. 2.D.</u> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 331X DUE TO (b) <u>Generalized arteriosclerosis with</u> DUE TO <u>hypertension</u> (c) <u>Cerebral hemorrhage with</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>myocardial infarction</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>3-10-1967</u> to <u>3-18-1967</u> that (I) (we) last saw the deceased alive on <u>3-18-1967</u> and that death occurred at <u>7P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>C P Ryland</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED <u>3-19-67</u>											
22c. PHYSICIAN'S NAME (Type) <u>C P RYLAND</u> 22d. ADDRESS <u>4400-49 St NW Washington D.C.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>											
23b. DATE THEREOF <u>3.22.67</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>											
23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>											
24. FUNERAL DIRECTOR <u>Lee's Funeral Home 300 4th St N.E.</u> ADDRESS											
25a. REC'D BY REGISTRAR <u>MAR 23 1967</u> DATE											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

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